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Juvenile Courts and the Gault Case

The Consultant in a Day-Care Center

Area Social Service Centers

Hospital Care in Great Britain

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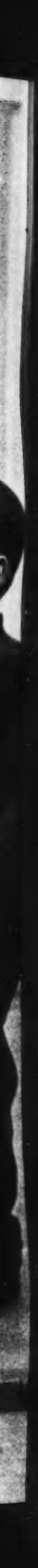

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A play doctor and nurse share a "professional" secret as an understanding day-care worker looks on. Knowing when to be part of the game and when to stay out is one mark of the day-care worker who is aware of the needs of deprived children and her ability to meet them. How a consultant on child development can help day-care workers grow in their jobs is described in the article beginning on page 97.

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In a historic decision last summer, the Supreme Court clearly brought children under the Bill of Rights. How will this affect the social purpose of the juvenile courts? Two lawyers discuss the . . .

At the turn of the century, new ideas for dealing with juvenile delinquents arose in this country and quickly spread throughout the Western World. There was widespread dissatisfaction with administration of justice as it affected children, especially with the practice of giving children long criminal sentences and mixing them in jails with hardened criminals. The leaders of the movement were convinced that society's duty to erring children was not discharged by the simple administration of the routine, impersonal criminal procedures then operating. They proposed that the States accept responsibility for making a diagnostic study of the child and his milieu and for prescribing a course of treatment that would help rehabilitate and perhaps completely reform him. They proposed quarantine rather than punishment for children needing physical control.

Underlying these proposed changes was the assumption that the causes of juvenile delinquency and the means of preventing further misconduct were known. Such knowledge was to be brought to bear upon children, much in the same way that scientific advances were being used to heal injury or cure disease. Children were to be "cured" of delinquency and restored to the community as useful citizens. Broad, summary powers were to be given to juvenile court judges to accomplish this purpose.

The judge, with his hand on the shoulder of the child, was to act as a wise and loving parent. He would induce or compel the child, with or without the parents' consent, to undergo care and treatment,

JUVENILE COURTS and the GAULT DECISION

I. BACKGROUND AND PROMISE

HOWARD G. BROWN

often custodial, for his and the community's best interest. His concern was to be not with what the child had done but with what he is and which of the many community resources and what part of the wide knowledge at the court's disposal should be brought to bear on him and his family to make them more socially acceptable and law-abiding.

The first juvenile court embodying these ideas was established in Illinois in 1899. Within a short time such courts were established in all of the States and in most other Western countries.

Innovations that start with great fanfare and high ideals and spread like wildfire often give rise to excesses, and this is what occurred in the juvenile court movement. Great departures from time-tested procedures took place in the name of salvage, rehabilitation, and correction, the beneficent end being held to justify almost any means. Law was supplemented and even supplanted by other social sciences in efforts to deal with a child's unacceptable behavior. While the compulsory nature of the courts and the legal system was retained, the safeguards of public hearing, counsel, due process of law, and formal procedure were discarded in view of the high intent and purpose of the courts and their supposed power and ability to help rehabilitate the child.

These juvenile court practices gained general acceptance. The summary procedures and lack of formality that became characteristic of them were approved by most appellate courts when questions about them were raised. Because juvenile proceedings were regarded as civil rather than criminal proceedings, the constitutional rights of the child were disregarded with impunity.

Unexpected problems

But unforeseen problems developed. Trained, skilled, and kindly judges were not always available to discharge the awesome responsibility of being a wise parent to all children in the community who were in trouble with society. Treatment resources, facilities, and staff with the necessary knowledge to diagnose and deal with the problems of a delinquent child were not adequately provided. The volume of delinquency cases became so unmanageable that enough time, staff, and resources were not available to enable the courts to give each case the intensive consideration, attention, and care needed.

Moreover, delinquency did not decline. Many children who went through the juvenile courts were not changed. Even under the most favorable circumstances, children were not always rehabilitated as the theory had promised.

People began to realize that while social science and medicine had made great strides in understanding human behavior, great areas were still unexplored. To make a diagnosis and a prognosis of a person's behavior, at least that of a troubled adolescent, turned out to be a complex matter about which much less was known than had been assumed. Courts and their staff members were not always able to find and use means of effecting the desired change in children. What a wise parent should be and do about a

bewilderingly complex child and the problems he presented the community was often a mystery.

Dissatisfaction with juvenile court justice also began to arise from the summary fashion in which juvenile proceedings were often carried out. Cases were processed without the child or his parents being given notice of the charges or apprised of the right to counsel. In fact, the right to counsel was often not recognized. Incompetent and untrained staff members were often used to make social investigations and administer social treatment. The judge often acted not only in his judicial capacity but also as prosecutor and defense counsel. It took superhuman ability to discharge these three functions with dignity, impartiality, and justice, and it often proved impossible to convince the parties that such functions had been so discharged. In many communities the courts had no treatment facilities to rely on—the institutions for juveniles were no more than junior jails.

Criticism of the juvenile courts mounted during the past decade. Articles appeared in law reviews criticizing the absence of due process and the deprivation of children's constitutional rights and privileges. Appellate courts began to recognize abuses that were taking place. Professional organizations began to take cognizance of the limitations and the difficulties involved. The National Council of Juvenile Court Judges, in 1961, began training programs for judges and conducted an institute on the role of attorneys in juvenile court. The University of Chicago held an institute on "Justice for the Child" in 1962. The National Council on Crime and Delinquency published a handbook on "Procedure and Evidence in the Juvenile Court" in 1962.

In 1966, the Supreme Court of the United States handed down its first decision involving the rights of children under a juvenile code in the case of *Kent* v. *United States*.[1] The Court pointed out that cases in juvenile courts were legal proceedings and that basic to the theory of any legal disposition was some concept of due process. The President's Commission on Law Enforcement and Administration of Justice in its report issued early in 1967 [2] pointed out the limitations of the juvenile courts and the crises that were occurring in them.

In re Gault

With so many expressions of dissatisfaction being made with the way juvenile courts were functioning, the decision of the Supreme Court in the Gault case,[3] handed down May 15, 1967, was hardly a surprise.

In the Gault case, a boy of 15 had been found delinquent by a juvenile court in Arizona and committed to a State institution for 6 years for a minor offense that would have been a misdemeanor had he been an adult. At the "trial" or informal hearing, he had not been represented by counsel, no prior notice of the charge had been given to him or his parents, no sworn testimony had been introduced, and he had been required to incriminate himself without warning of any privilege against self-incrimination.

The very fact that the Gault case, disclosing such a bad state of affairs, could get all the way to the Supreme Court, after having gone through a trial court and a review on habeas corpus at the trial level and on appeal to the State supreme court, was substantial evidence that something was drastically wrong with both the theory and practice in juvenile delinquency proceedings.

Basically, the decision recognizes and extends the principle set forth in the Kent case: that due process of law applies to juveniles in an adjudicatory hearing as well as to adults. The Court was unwilling to establish a new or specialized class of due process for children. It found that the traditional constitutional safeguards are necessary protections and must be applied in that part of juvenile proceedings concerned with determining whether or not the State has a right to intervene in the lives of children and their families.

Specifically, the Court holds that in cases that may involve custody, transfer, and institutional placement of a delinquent child, the following constitutional rights must be observed:

1. Adequate and specific notice in writing of the charge of alleged misconduct, set forth with particularity, must be given to the child or his parents in advance of the court hearing so that a reasonable opportunity to prepare a defense will be afforded.

2. At an adjudication hearing that may result in

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curtailment of the freedom of a child, the child and parents must be notified of the child's rights to be represented by counsel unless knowingly and intelligently waived. If they are unable to afford counsel, they must be advised that counsel will be appointed at public expense.

3. The privilege against self-incrimination is as applicable in the case of juveniles as it is with respect to adults, unless intelligently waived.

4. In the absence of a valid confession or admission, a determination of delinquency must rest upon sworn testimony in open court from witnesses whom the accused has had opportunity to confront and cross-examine.

The majority opinion expressly excepts from the effect of this decision anything that happens in the court prior to the hearing on adjudication and any proceedings held in regard to the disposition of a case. It does not guarantee, however, that questions of constitutional rights may not hereafter be raised with reference to what happens before or after the adjudication hearing. In effect, it challenges the various States to find ways and means to operate these pre- and post-adjudicatory proceedings that will not infringe on children's interests under the Bill of Rights and that will retain the unique merits of the original vision of juvenile courts.

The possible effect

Contrary to some expressed opinion, the Gault case does not sound the death knell of the juvenile court in the United States. The fundamental concept of treatment and rehabilitation is not disturbed. But the court's right to deprive a child of freedom in providing treatment is limited to delinquency cases in which it has been established, by a trial in which due process is observed, that the State has a right to intervene.

Adherence to the precepts of due process in the trial will increase the demands on the juvenile courts in terms of time, expense, and procedural regularity. It may cause some courts to withdraw from precourt study and examination and from such treatment programs as informal probation and to limit their post-trial proceedings to referrals for study and treatment.

However, children are more likely to have a fair and impartial hearing and to depart from the hearing with the impression that justice has been done. This may render them more amenable to change.

The juvenile court movement has not been set backward by this decision. Rather, it has been given new direction and guidelines for operating when legal process is brought to bear on the activities of young people.

Facing realities

The juvenile court, as a social institution, has had many salutary effects on other institutions. Its philosophy has provided an example for improving methods of social control of deviant behavior in adults. The widespread use of probation, the increasing practice of releasing persons without bail, the provision of treatment and rehabilitation, the reliance on the skill of the social and physical sciences, and the beginnings of scientific research into social problems—all of these developments have been fostered, developed, encouraged, and, in part, made real by ideas generated and illustrated by work done in juvenile cases.

But the limitations of professional skill in dealing with the problems of maladjusted adolescents must be recognized, as must the widespread failure to bring what knowledge and skill are available to bear upon these problems. Such recognition may ultimately lead to some substantial rethinking of some of the methods of operating social controls.

Progress means change, and change means holding conclusions as tentative and not as absolute truths. The hypothesis of yesterday must give way to the realities of today to give hope to tomorrow.

The founders of the juvenile court movement were idealistic, dedicated, hard-working people. From their vision and devotion we must gain new dedication to give new leadership to the movement's new direction. The National Council of Juvenile Court Judges, the National Council on Crime and Delinquency, the Children's Bureau, the American Bar Association, the National Association of Social Workers, foundations, universities, and other groups must take up the challenge to make the dreams of the future more effective. Perhaps then we can come closer to the ultimate goal of scientific diagnosis and treatment of human behavior problems.

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[1] *Kent* v. *United States*, 383 U.S. 541 (1966).

[2] President's Commission on Law Enforcement and Administration of Justice, Task Force on Juvenile Delinquency: The challenge of crime in a free society. Washington, D.C. 1967.

[3] *In re Application of Gault*, 387 U.S. 1, 87 S. Ct. 1428 (1967).

JUVENILE COURTS and the GAULT DECISION

II. AN INVITATION TO INNOVATION

WILLIAM T. DOWNS

To interpret the meaning of the decision of the Supreme Court of the United States in the Gault case,[1] it is well to examine precisely what the Court did and did not say. First, consider a description of the facts under review:

In brief, the essential facts of this case are: Gerald Gault, 15, was petitioned into court as a "minor . . . in need of protection . . . and . . . a delinquent minor." No facts were recited in the petition, but its basis was an alleged lewd and obscene telephone call to a Mrs. Cook. Gerald was placed in detention. No notice was given to his parents. When Mrs. Gault inquired at the detention home about her son, she was told that a hearing would be held the next day. No record of that hearing is available, and recollections of participants at the hearing are in conflict about whether Gerald admitted making the remarks. The matter was adjourned. Gerald was detained 3 days and then released. On the day of the release, Mrs. Gault received a note on plain paper from the police saying "a hearing on Gerald's delinquency" would be held June 15, 1964. At this hearing, Gerald did *not* admit that he had made lewd remarks, the participants later agreed. Gerald said he had dialed the number and given the phone to another boy. Mrs. Gault had asked for Mrs. Cook to be there. Mrs. Cook did not appear at either hearing. The judge found the boy to be delinquent and committed him to the State industrial school.

Subsequently, the judge gave as the bases for his action a violation of the Arizona Criminal Code making it a misdemeanor to "use vulgar, abusive or obscene language" in the presence of or hearing of any woman or child and a definition in the juvenile code of a delinquent child as one who is "habitually involved in immoral matters."

The appellant had asked the Court to consider the following basic rights: (1) right to a notice of the charges; (2) right to counsel; (3) right to confrontation and cross-examination; (4) privilege against self-incrimination; (5) right to a transcript of the proceedings; (6) right to appellate review.

While the Court considered each of these rights, it did not make a definitive finding on each. Moreover, it carefully limited all of its findings and assertions to the precise situation presented in the Gault case: *where the result may be a finding of delinquency and the commitment of the child to a State institution.* In other words, it did not speak of a hearing regarding neglect or even of a hearing regarding delinquency where the disposition does not involve institutional confinement. However, we can infer from its findings in this case what the Court for consistency would likely hold. The Gault case, said the Court, represented "failure to observe the fundamental requirements of due process." And, "due process of law is the primary and indispensable foundation of individual freedom. It is the basic and

essential term in the social compact which defines the rights of the individual and delimits the powers which the State may exercise." Speaking through Justice Fortas the Court held that—

> 1. Due process of law requires notice . . . which would be deemed constitutionally adequate in a civil or criminal proceeding. It does not allow a hearing to be held in which a youth's freedom and his parents' right to his custody are at stake without giving them timely notice, in advance of the hearing, of the specific issues that they must meet.
>
> 2. . . . the Due Process Clause of the 14th amendment requires that in respect of proceedings to determine delinquency which may result in commitment to an institution in which the juvenile's freedom is curtailed, the child and his parents must be notified of the child's right to be represented by counsel.
>
> 3. . . . the constitutional privilege against self-incrimination is applicable in the case of juveniles as it is with respect to adults. We appreciate that special problems may arise with respect to waiver of the privilege by or on behalf of children, and that there may well be some differences in technique—but not in principle.
>
> 4. . . . absent a valid confession, a determination of delinquency and an order of commitment to a State institution cannot be sustained in the absence of sworn testimony subjected to the opportunity for cross-examination in accordance with our law and constitutional requirements.[1]

The Court did not rule on the juvenile court's failure to provide a transcript nor on the judge's failure to state the grounds for his conclusion.

Since juvenile courts are purely statutory courts, the Supreme Court found itself in a delicate position. It could either find the Arizona statute establishing the juvenile court to be unconstitutional, as Justice Black did in his separate opinion, or, accepting the statute, it could find that the procedures were not in accord with constitutional guarantees. If it had found the statute unconstitutional, the juvenile court statutes in the 50 States would have been thrown into question. Indeed the Gault decision can be regarded as a warning to State legislators to determine in the future what must be done by statute to assure due process in the juvenile court and what can be left for the court to determine by rules or policies.

The reach of the Gault decision is further circumscribed by the Supreme Court's self-imposed limitations. The Court said:

> We do not in this opinion consider the impact of these constitutional provisions upon the totality of the relationship of the juvenile and the State. We do not even consider the entire process relating to juvenile "delinquents." For example, we are not here concerned with the procedures or constitutional rights applicable to the prejudicial stages of the juvenile process, nor do we direct our attention to the post-adjudicative or dispositional process. . . . We consider only the problems presented to us by this case.[1]

The Court recognized that there can be differences between juvenile courts and thus allowed for flexibility in applying its rulings. While this resulted in some lack of precision as to legal reasons and authority, it nevertheless encourages an open-minded approach. Apparently the underlying rationale for the Court's decision is one of fundamental fairness, even though the Court did not explicitly so state.

In its deliberations the Court looked beyond and behind the rhetoric of procedures to see what, in fact, was happening to young people in the juvenile courts. This is evidenced by the Court's refusal to accept the tendency of juvenile courts to hide behind the term "civil" even though their decisions may result in the loss of liberty or the term "custody" when they mean confinement. It is also evidenced by its reference to published articles that had been critical of juvenile courts because of the kinds of facilities often used and the lack of treatment resources.

The adjudication stage

There seems to be little dissent from the proposition that due process requirements should apply at the adjudication stage. As Justice Fortas pointed out, the question of means is at issue rather than the principle. The decision makes clear that these means must protect the juvenile's right to notice of the charges, to counsel, and to confront and cross-examine his accuser and his privilege against self-incrimination.

Notice. Nothing is clearer in the Gault decision than the necessity of giving the juvenile and his parents the kind of notice "deemed constitutionally adequate in civil or criminal proceedings." This means notice of the hearing well in advance and information about the specific issues that the respondent must be prepared to meet at that hearing.

By not electing to rest this element of its decision on a specific clause of the Bill of Rights or upon the 14th amendment, the Supreme Court seemed to be saying that the right to adequate notice is so deeply engrained in both the civil and criminal law that it requires no further justification. The idea of carrying on any kind of hearing without properly notifying persons who must defend themselves should violate anyone's sense of fairness and is completely alien to any defensible judicial standards.

In referring to notices in civil or criminal proceedings, the Supreme Court invites flexibility and experimentation in providing notice. Thus it has issued an invitation to innovation. It would be tragic

indeed if the juvenile courts were to transfer intact from the criminal courts practices that are antiquated or are irrelevant to the juvenile courts. For example, the typical notice in a criminal case is written in complicated legal language. Juvenile courts should make a determined effort to draft notices in language that is understandable to the average citizen.

Again, the citing of the criminal statute is a required practice in criminal law. I doubt that this necessarily applies in the same way to juvenile court proceedings. The rationale for requiring the citation of the statute in a criminal case is the difference in degrees of offense and the different consequences imposed by the criminal law. In juvenile courts, theoretically at least, no degrees of offenses are recognized (although there are different types of cases, for example, neglect and delinquency). Differences in consequences are based upon the treatment needs of the individual rather than having been imposed by legislation. The acts comprising the juvenile's alleged misconduct must be clearly specified in the notice so that he may prepare to defend himself. But this still leaves room for flexibility in policy regarding the citing of a specific statute or ordinance or making a formal charge against the juvenile in the language of the law.

One critical question arising from the Gault decision has to do with whether or not its rulings apply retroactively. Certainly the ruling requiring an adequate notice would seem to be retroactive. In pointing out that adequate notice has always been a requirement in both criminal and civil proceedings, the Supreme Court nullifies the argument that because juvenile court proceedings are civil proceedings they are exempt from this procedural requirement of criminal law. The fact that a juvenile has been committed to an institution without proper notice of the charge against him should be a basis for a court review.

Right to counsel. Justice Fortas based his conclusion about the right to counsel on the 14th amendment. The Court obviously considered this decision to be consistent with its ruling on criminal matters. It said: ". . . we hold now that it (assistance of counsel) is equally essential for the determination of delinquency." [1]

The assistance of counsel means that at the earliest point in the adjudication process, that is at the time of notice of hearing, the court must not only allow counsel chosen by the respondent to participate in the proceedings but must also advise the respondent of his right to be represented by counsel and appoint counsel for him if he is indigent.

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The proper exercise of the right to counsel presents some thorny questions for the juvenile court: Who exercises the right, the parents or the child? Can a minor, legally incompetent, competently waive a right to counsel? Frequently, the interests of parents and child are not the same. Certainly when this is evident, counsel should be appointed specifically for the child.

The Court was silent about whether or not this ruling must be applied retroactively. Although the Arizona Supreme Court has already released two juveniles on the basis of this ruling, pragmatic reasoning would seem to be against a general retroactive application. Except in States where counsel is required by statute, the accepted practice in juvenile courts for many years has been neither to advise nor appoint counsel for respondents.

In a recent case the Supreme Court of the United States ruled that procedural defects "must be weighed against the prior justified reliance upon the old standards and the impact of retroactivity in the administration of justice." [2]

Self-incrimination. In the Gault decision the Court said, ". . . the constitutional privilege against self-incrimination is applicable in the case of juveniles as it is with respect to adults," thus adopting the principle for juveniles without reservation. Yet the Court again offers juvenile courts an invitation to innovation, by recognizing that the means and method of implementing the privilege may require "some differences in technique." [1] Here again, the juvenile courts might be remiss in transferring in total the techniques of the criminal court. They should recognize that criminal court procedures, no matter how hallowed by time and observance, are only forms that have been adopted to express the

principle of the privilege. The courts should invent new forms to make the principle meaningful for the juvenile.

In its discussion, the Supreme Court pointed out that one reason for the privilege is the essential untrustworthiness of confessions.[3] The Court implied that this reasoning is even more persuasive in respect to children than adults, by pointing out two peculiarities of juveniles: (1) their tendency when surrounded by adults to seek to please those adults and (2) their tendency to react with hostility if after they have complied with the adults' urges to make a clean breast of it they are then subjected to disciplinary action. In the latter instance, the Court suggested, the juvenile attaches his hostility not only to the proceedings engendering it but also to the whole process of order and justice.

If there is one impression that makes further treatment of the young person almost impossible, it is that of having been treated unfairly.

Again the question of retroactivity arises. Since the privilege against self-incrimination can be claimed in any proceeding, civil or criminal, cases in which commitments to institutions have been based upon involuntary confession should be the subject of prompt and careful review. The test should be whether or not a confession was made voluntarily or under compulsion.

Sworn testimony and cross-examination. The decision leaves unanswered several questions about evidence, particularly about the admission of hearsay and the standard of proof of delinquency (whether this can be based on "preponderance of evidence" as distinguished from "beyond a reasonable doubt"). However, the decision clearly requires that proof be based on sworn testimony—presumably not hearsay—subjected to cross-examination.

This requirement should have a salutary effect on juvenile court proceedings. It promises greater fairness to the defendant. It also promises increased order in the proceedings by cutting down on the amount of "junk" information admitted—hearsay so remote from firsthand evidence that it is no more than gossip and rumor.[4] The result should be a higher standard of performance on the part of court workers and of police in the investigation and preparation of delinquency cases.

Again, pragmatic reasoning argues against the retroactive application of the requirement. In the past, many juvenile courts in the interest of informality have dispensed with the cross-examination of witnesses. A chaotic condition would exist in the courts if all such cases had to be reviewed or invalidated.[2]

In complying with this requirement, juvenile courts need to be imaginative in respect to the use of testimony from juvenile witnesses and to devise techniques of cross-examination to protect them from unnecessary trauma. In devising these procedures, the courts should get the best advice available from behavioral scientists. If the objective of such hearings is to arrive at the truth, the courts have here an opportunity to improve the conventional techniques for seeking truth.

Preadjudication stage

In practice, the preadjudication stage of proceedings in the typical juvenile court consists of two separate parts. The first is the intake procedure through which the complaint is received and an investigation made. The second, at least in some courts, is a preliminary hearing to determine if a formal hearing should be held. This procedure approximates the preliminary hearing in a criminal court to determine whether there is reasonable cause to believe that the offense has been committed and that the accused committed it.

The basic notions of fundamental fairness must of necessity be applied in the preadjudication stage, but the road to application will be difficult and tortuous. Certainly the Gault decision implies that the intake procedure cannot be used to fish around for something against the juvenile, as it so often has been used in the past.[5] Investigation will have to be confined to the questions raised by the initial complaint. No longer can a court base the adjudication hearing entirely on alleged offenses discovered during the period of investigation.

There may be some ingenious minds at work planning to avoid the impact of the Gault decision by moving more of the court process into the preadjudication stage. The recommendations coming from some sources for informal adjustment and consent decrees have a familiar ring. This is the same kind of rationale advanced for the establishment of the juvenile court in the first place. But the requirement for procedural safeguards to assure fairness cannot be met by calling a matter "informal" any more than it can by calling the procedure "civil." Coercion cannot be hidden by calling it a "consent decree." The Court is always coercive,[6] as is any confrontation of the citizen with the power of the state.

Great ingenuity, compassion, and resolute adherence to a concept of fairness are required to make informal proceedings truly informal and at the same time in accord with fundamental ideas of individual freedom. Although the Supreme Court did not explicitly rule on the preadjudication stage, adequate notice of hearing and the privilege against self-incrimination are rights that undoubtedly must be associated with the preadjudication stage. The precise technique of assuring them is yet to be defined. Innovation is again in order, but care must be taken

Complainant, mother, and alleged juvenile delinquent face the judge in a juvenile court hearing. How both the social needs and the legal rights of an accused child can be protected in a court hearing is discussed in the accompanying article.

to avoid presenting the juvenile, explicitly or by implication, with a choice of two evils in the form of an "informal adjustment" or "a consent decree."

In most juvenile courts, intake procedures are administered by persons who are not lawyers. While the rhetoric of the juvenile court implies an intake procedure that makes decisions about children according to their needs, in practice the decisions are usually made on the basis of classifications closely paralleling the seriousness of the offense. If the courts are to pursue their promise, criteria for intake decisions will have to be established. The courts should call on social and behavioral scientists to define such criteria; but they must rely on lawyers to establish procedures for applying these criteria so that the procedures may be consistent with fundamental due process requirements. Otherwise renewed attacks upon the juvenile court and the imposition of stringent procedural safeguards may ensue.

One difficult question often raised by persons who are not lawyers is how a court should deal with a child who has exhibited a pattern of behavior no single act of which constitutes a serious offense. Here again, the law needs help. I know of no determined attempt to adequately lay the foundation for a decision on this issue. In the Gault case, the juvenile court judge had found Gerald Gault "habitually involved in immoral matters" because of three previous "offenses": he once "was with" a boy who stole a purse; he admitted having made "silly calls or funny calls"; and he had once "stolen a baseball glove from another boy and lied to the police department about it."[1] True, the typical juvenile court file in a case involving a pattern of immoral behavior would not be so barren of evidence, but frequently such files contain only secondhand or thirdhand information about the alleged acts constituting the pattern. I recall a file that referred to 28 separate acts of the juvenile, only four or five of which had been checked out.

Certainly the acts said to constitute a pattern must consist only of those ascertained on the basis of creditable evidence. Once the court has reasonably established the fact that the acts did take place, the social scientist has the responsibility for interpreting their meaning in terms of the juvenile's needs and the proper course of treatment indicated.

Many persons connected with juvenile courts may say this kind of probing and thoughtful attention places an unreasonable burden on already overburdened juvenile court staffs. Certainly the courts will have to secure additional staff members, facilities, and other resources. But they must also use available resources more efficiently and effectively. More systematic screening procedures during the initial phases of the process may substantially reduce the strain on limited resources.[6]

In the Gault case the juvenile court had committed Gerald Gault to a State institution for a possible period of 6 years, even though he was living with both his parents and an older brother. Institutional commitment of juveniles who have given no evidence of danger to themselves or others was not an unusual practice in juvenile courts. In view of the shortage

of institutional space and the burden on court staff, if for no other reason, it would seem that judicious *non*intervention should be the guiding principle of the juvenile court.

The social work approach of helping, of talking it out, of providing support, of gathering social data may seem to be at odds with the legal approach. But if the representatives of the legal and social work professions sit down together to list the fundamental principles involved, the conflict between them may be narrowed, and they may find that humanitarianism and justice are not necessarily inconsistent. Then working together, the two professions can set about the task of devising methods for court work that will be consistent with the legitimate objectives of law and social work.

Detention. Concurrently with the intake process, a preliminary hearing may be held to determine whether the juvenile should be detained pending the disposition of the case. Here again the highly valued right of individual freedom is at issue. All the rights specified in the Supreme Court's decision in the Gault case, plus the right to a prompt hearing as guaranteed in the criminal law, would seem to be applicable to juveniles. This principle calls for substantial change in present practice. In many communities, current detention practices substantially are accommodated to police convenience. A task force report of the President's Commission on Law Enforcement and Administration of Justice shows an average period of 12 days detention per juvenile detained.[6] The decision to detain ought to be a judicial determination.

As the Children's Bureau recommends, detention should occur only when there is danger to the child or community.[7] If no such danger exists, procedures should accomplish prompt release after arrest. If criteria for detention or release are carefully established, procedures of the preliminary hearing should not run afoul of constitutional law.[8] The application of the principles spelled out in the Gault decision to the preliminary hearing should have the salutary effect of reducing the overcrowding of detention facilities and the practice of confining children in jail.

Search and seizure. Few persons would dispute the theory that the privilege against unreasonable search and seizure provided for in the Bill of Rights exists for the benefit of juveniles as well as adults. In the few cases where the issue has been raised, the privilege has applied.[9] However, the privilege has frequently been ignored because lawyers have rarely participated in juvenile court proceedings. Because of the increased appearance of lawyers in the juvenile courts since the Gault decision, this privilege is likely to be exercised more often in the future.

Post-adjudication stage

Undoubtedly, many issues that are being raised about the post-adjudication stage of the juvenile court proceedings, excluded from the Gault case, will be the subject of Supreme Court review sometime in the future. Juvenile courts might well take some precautions to assure fairness to the juvenile defendant and a measure of security to current juvenile court dispositions.

Under no circumstances should information pertaining only to disposition be available to the judge before the disposition stage. The interested parties, including the juvenile, his parents, and counsel, if one has participated in the case, should be given adequate notice of the dispositional hearing and of the possible results. The counsel should also have an opportunity to question the persons who are making recommendations regarding the disposition of the case. This means that the staff of the court and of any outside resource making recommendations must be prepared to justify clearly those recommendations. Files or records taken into consideration in the making of the disposition should be available for counsel to examine.[7] The counsel should also be allowed to present expert testimony recommending a different disposition if he wishes.

At this stage, the court social worker must assume the burden for clearly defining to the juvenile, his parents, and counsel the reasons for the disposition and its advantages over any other and for devising a method of measuring the juvenile's progress within the plan. The social worker, not the lawyer, has expertise in understanding juvenile behavior and the techniques for changing it. In the absence of counsel, the role of the social worker is more crucial and exacting. These responsibilities require a substantial change in the performance of many court social workers and a keen assessment of the skills of diagnosis and prediction of behavior. The degree to which the social work profession responds to this challenge may well determine whether the present concept of the juvenile court as an agency to provide treatment in the best interest of the child will continue to exist.

In other words, the rights of notice, counsel, sworn

testimony, and cross-examination should apply at the time of disposition as well as in adjudication, although the method employed to protect those rights may be different. The dispositional hearing should not be viewed as an adversary proceeding, but rather as a proceeding in which all involved are interested in arriving at a disposition that will be best for the juvenile, although opinions may differ about *what* is best. Rules of evidence at the dispositional hearing should be broad and flexible.[10]

In recent years, courts have shown an inclination to find out whether punishment or treatment is provided as a result of their determinations. In Washington, D.C., for instance, the courts have inquired into the treatment of mentally ill persons,[11] alcoholics,[12] and drug addicts.[13] This challenges the juvenile courts to make similar inquiry regarding the resources they have used. The courts may fear that meticulous attention to the reasons for and goals of their dispositions may arouse objections to the dispositional process. But it is also likely to increase community interest and stimulate the establishment of the necessary resources. According to the Supreme Court—

> **The observance of due process standards, intelligently and not ruthlessly administered, will not compel the States to abandon or displace any of the substantive benefits of the juvenile process.[1]**

THE DECISION of the Supreme Court of the United States in re Gault provides an opportunity for realizing the promise of the juvenile court and contributing to criminal justice as well.

The decision is a call for honest reappraisal and a call for action. The courts have a resource for action in their talented and dedicated staffs. Do they have the imagination, and the will, to use them?

If they do, they can prove that consideration, compassion, treatment, rehabilitation, fairness, dignity, protection, and respect are all included in the term *justice*.

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[1] *In re Application of Gault*, 387 U.S. 1, 87 S. Ct. 1428 (1967).

[9] *Stovall* v. *Dewar*, 388 U.S. 293 (1967).

[3] Wigmore, *Evidence*, § 822 (3d ed. 1940).

[4] President's Commission on Law Enforcement and Administration of Justice, Task Force on Juvenile Delinquency: The challenge of crime in a free society. Washington, D.C. 1967.

[5] Demert, E. M.: The juvenile court-quest and realities. *In* Juvenile delinquency and youth crime (appendix D). Task Force on Juvenile Delinquency, President's Commission on Law Enforcement and Administration of Justice, Washington, D.C. 1967.

[6] President's Commission on Law Enforcement and Administration of Justice, Task Force on Juvenile Delinquency: Juvenile delinquency and youth crime. Washington, D.C. 1967.

[7] Sheridan, William H.: Standards for juvenile and family courts. U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau, Washington, D.C. 1966.

[8] Dorsen, Norman; Rezneck, Daniel: In re Gault and the future of juvenile law. *Family Law Quarterly*, December 1967.

[9] Lefstein, Norman: In re Gault, juvenile courts and lawyers. *American Bar Association Journal*, September 1967.

[10] President's Commission on Law Enforcement and Administration of Justice, Task Force on Administration of Justice: The courts. Washington, D.C. 1967.

[11] *Rouse* v. *Cameron*, 373 F2 451 (D.C. Cir. 1966).

[12] *Robinson* v. *United States*, 370 U.S. 660 (1962).

[13] *Easter* v. *D.C.*, 361 F. 2d 50; 124 U.S. App. D.C. 33 (1966).

> **. . . In time, we shall create the institutions and the habits of life, the rituals, the laws, the arts, the morals that are essential to the development of the whole personality and the balanced community: the possibilities of progress will become real again once we lose our blind faith in the external improvements of the machine alone. But the first step is a personal one: a change in direction of interest *towards* the person. Without that change, no great betterment will take place in the social order. Once that change begins, everything is possible.**
>
> *Lewis Mumford*, "The Condition of Man," *Harcourt, Brace & Co., New York, 1944.*

some observations on the role of . . .

the CONSULTANT

in a DAY-CARE CENTER for DEPRIVED CHILDREN

LOIS BARCLAY MURPHY

Experience as a consultant on child development and observation of day-care centers initiated by neighborood groups under the Office of Economic Opportunity community action programs have left me with conclusions that others concerned with the work of such centers may find helpful. My recent work was conducted with support from the Menninger Foundation (Topeka, Kans.) and the National Institute of Mental Health.[1] My approach, however, grew out of observation at many day-care centers throughout the United States and around the world and from participation in the Sarah Lawrence College Nursery School (Bronxville, N.Y.) for many years.

The first consideration of the consultant on child development in working with day-care centers for severely deprived children is the relation of his work to the nature of the center. In such a center, staff members are likely to be heterogeneous and the problems new and complex compared with those of a typical day-care center.

Because of the shortage of professional people, the center's only fully trained staff member may be a young director fresh from university training. She may have had excellent experience in the training center, but none in a position of authority or in a center in an extremely poor neighborhood. Her staff will be made up mostly of untrained people drawn from the neighborhood. A few may have completed some college work, including work in education, but most will have barely completed high school and will have had little or no training in understanding the needs of preschool children in general and practically none in understanding the needs of children whose parents are deprived, disturbed, or ill. However, they will have the advantage of knowing the neighborhood, and some of them will have wisdom gained from their experience in bringing up their own children.

Limitations of space and equipment not adapted to or planned for preschool children also require special thought from and perspective in the consultant.

Because her staff members have varying degrees of training, the director has to keep in mind the need for clarification of very elementary goals that would ordinarily be taken for granted by a staff with more nearly uniform backgrounds in early childhood education. At the same time, the consultant will have to offer another type of help to any staff member whose goals reflect the needs of overstimulated children from the toy-loaded homes of many middle class families.

No matter how solid and broad her training has been, if the director lacks wide experience with children from different backgrounds, an immense gulf

may exist between her assumptions and ideas about how to work with the children and the beliefs of her neighborhood staff members. On the one hand, even if they have had some college training, neighborhood workers may unconsciously cling to the ideas of their subculture about handling children, though such ideas often conflict with the middle class standards for and methods of dealing with children that characterize training for social workers and teachers. Autocratic, harsh, abrupt ways of "making the children mind" and a punitive attitude toward "making a mess" with fingerpaints or sand may bump against the director's awareness of the benefits to children of experience with these materials in learning (about color, space, and form) and in the development of controlled expressiveness. On the other hand, the director may not have had a chance to recognize and accept the often healthy effects of a rough-and-ready, yet warm, stimulating, and supportive method of child care that balances "no-nonsense" discipline with affection.

Relations with staff

Some of the neighborhood staff members may be mature women who are consciously or unconsciously suspicious, scornful, or even hostile to a "young, inexperienced chick" who lacks their kind of experience, and they may extend these feelings to the consultant. If the consultant has had their kind of experience in bringing up children and understands and appreciates the contributions each member of the staff can make, a warm mutual respect and tolerance will evolve.

In such a complex, mixed, and touchy situation, the consultant on child development has to realize that his role is different from that carried by most consultants. As he knows, a *medical* consultant is expected to provide an authoritative diagnosis and to help the physician in charge of a case bring order out of conflicting data. A *planning* consultant on human needs called in to help plan a new city is expected to make suggestions regarding his particular field in relation to architecture. His training in understanding human development and needs—knowledge basic to good planning for a new city—may be gladly accepted by the architects. In these situations, the persons seeking expert advice know what they expect from consultants.

By contrast, the consultant in the day-care center is working with people who are not accustomed to making use of a consultant. They only vaguely understand the consultant's emphasis on helping a child develop and may be highly sensitive to what they take to be criticism. They may even take constructive suggestions as criticism if the suggestions conflict with their procedures and ideas.

Consequently, whereas a relationship between a consultant and the people asking for consultation usually develops easily in medicine or research, that between a consultant and the staff of a neighborhood day-care center has to develop as an outcome of the gradual growth of respect in the consultant for the staff members' widely varying personalities, experience, talents, and potential for contributing to the work of the center and the response of the staff to his appreciation. A relationship built this way can help staff members identify themselves with the consultant and assimilate and apply suggestions from him that "prove out" their value.

The first task of the consultant on child development, then, is as much to help build mutual respect and self-confidence in the staff as it is to make the staff aware of the needs of the children they serve. He will completely avoid destructive criticism and will support the positive efforts of the staff at every possible point; that is, he will help staff members become more aware of their potentialities and of the contributions they can make to the center's program, the way these supplement each other, and how they can be made to grow.

The consultant will avoid autocratic ways that could undercut the maturing process in the staff. He will avoid dictating to, talking at, or overtalking to the staff and will above all encourage staff members to express their thoughts, observations, beliefs, and feelings and to consider all of these fully in relation to the development of the children. In other words, the consultant will not work like a bureaucrat or a member of a hospital hierarchy who must adhere to a rigid role. He will try to be an experienced partner, friend, or guide who is primarily concerned with promoting growth in staff members and in their relationships and greater understanding in them of the needs of individual children.

In following this method of supporting growth in the staff, the consultant can use definite ground rules at crucial points—such as the absolute requirement to protect the safety of children. To illustrate: because in a deprived neighborhood children may be allowed to play with little supervision, staff members may be unaware that the danger of play on swings or climbing apparatus is increased when a larger number of children are playing on them than would

be on a regular playground. In such an instance, the consultant may have to firmly state the kind and amount of supervision required.

However, in discussing many other aspects of work with the children, the consultant can build on the spontaneous efforts of the staff and reinforce the best of them by explaining their importance. For instance, if a staff member spontaneously gets down on the floor to help a child see what can be done with building blocks, the consultant can use this as an example in a discussion with the staff. He can bring out the importance of adults sharing experience with children who do not have blocks at home and do not know how to put them together. The adult can help the child understand such ideas as "bridge," "row," "gate," and "roof," and help him learn how to deal with the basic problems of weight, size, and shape. By building on the staff's spontaneous acts, the consultant can widen their perspective on the educational value of each activity.

The consultant can also show the staff the way in which *every activity in the day-care center can be an occasion for conversation that will increase the child's vocabulary and enlarge his capacity for communicating in a natural, highly motivated, and spontaneously reinforced way.* He can point out how snack times and mealtimes can be occasions for teaching words. Many children from poor neighborhoods live on meager diets at home and know the names of only a few foods. At the center, after the children have eaten such foods as meat loaf, carrots, mashed potatoes, graham muffins, and apple salad, staff members can ask such questions as, "Do you like carrots? Would you like another helping of meat loaf?" Because their answers—and soon their requests—bring gratification, the children's realization of the value of talking is reinforced in a natural way.

In a similar way, the consultant can show staff members how to help the children expand their conversation to include descriptions of what they see. If every remark a child makes is respected and receives an interested answer, he will acquire a wider base for conversation.

The same principle can be followed in regard to the stimulation of independence, in which serving oneself food plays an important part. Children in good day-care centers help set and clear the table, pass the crackers or muffins, pour their own milk, and, by the age of 4, often serve themselves from main dishes.

So far, I have discussed elementary considerations about ways in which a good consultant can foster the maturing process and the growth of understanding in the staff to help them identify with procedures that will support the development of the children. I will now back up to consider some of the consultant's assumptions and the ways in which he needs to think about them.

The consultant avoids an automatic or mechanical application of the principles of child care and development acquired from experience in middle class day-care centers. Middle class children are often overmothered and overstimulated and, as a result, may be overly verbal. Or they may be overcontrolled and inhibited and have poor ability to express their feelings. Such children bring needs to day-care centers different from those of children from extremely poor environments: often they only need to be let alone to work out their own ideas.

Very deprived children may lack more than the

A group of children in a day-care center learn to act out a story through expressive dance

toys, materials, food, clothing, and attention available to many middle class children. Often their mothers can pay little attention to them because they are exhausted, harassed, and too busy with young babies (and the insuperable problems of caring for families in inadequate homes) to provide the kind of stimulation that most middle class children receive. In the deprived child's home, conversation may be squelched and curiosity discouraged. Consequently, the consultant will need to determine the kinds of experience the children he is working with need. He should not take anything for granted but should work from the beginning, as steadily as possible, to evaluate the neighborhood and the strength of the children (such as the spontaneous way they take responsibility for each other and their autonomy). He will need to evaluate not only the gaps in every aspect of development, but also the precosity that sometimes appears in children who have been exposed early to crime, mistreatment, or adult sexuality. He may need to help the staff recognize distrustfulness in the children or the connections among vulnerability, hyperactivity, and aggression.

Kinds of poverty

The consultant's evaluation could include distinguishing among the various kinds of poor people that might be present in a large group—broadly, the temporary poor, the "poor by choice," and the chronically poor. The first two kinds can usually respond to the work of the center without help; the third kind can only accept the center with help.

Temporarily poor families include those headed by young parents just making their way in the world; those with breadwinners temporarily out of work because of illness or for other reasons; and those relying on seasonal work for income. Parents in such families may have middle class standards and goals, may be ready to use the stimulation offered by the day-care center, and may understand the center's purpose even though they lack the resources to provide toys and books or are too tired and anxious to provide stimulation to their children as they would like to. Or the family may be temporarily poor because of a traumatic condition such as the death of the head of the family or severe illness or incapacitation in him. Or the family may be exhausted or discouraged by a series of misfortunes. Such families can be responsive to the day-care center and may be ready for active, friendly support for themselves.

The "poverty by choice" family is headed by the "creative noncompromiser"—the artist, the sculptor, the musician—who, dedicated to a creative life at any cost, lives on a pittance. The parents in such a family can respond quickly to the efforts of the day-care center because they want their children to have experience in an environment richer than the one they can provide.

Then there is the poverty of the chronically poor—the discriminated against, the trapped, the retarded, the disturbed, the "alienated." Parents in such families may regard the day-care center with suspicion and resistance and be unwilling to receive its ideas. The consultant may have to guide the center's staff toward working gradually and gently to obtain the trust and respect of these people and to involve them step by step by reaching out to them, following their own leads, and building a relationship at first through friendly interest in the child—in short, through giving as much as possible of themselves to those who are unwilling to cooperate because nothing has ever been given to them.

Parents who are vulnerable, inadequate, and neurotically dependent, who cannot get jobs because they have character disorders or are psychotic, and who are losers or failures may present many difficulties to the center. They may have neglected or battered their children; they probably lack stimulation. The center may need to develop through trial and error specific and different ways of reaching, working with, and gaining the respect of these parents.

Similarly, the apparently chronic poverty of families on "hereditary welfare" may seem to go along with indifference, resistance, or suspiciousness. Yet these families, too, can be reached if the consultant can help the day-care center staff work for the gradual development of the family's potentialities through respect and appreciation.

Along with evaluating the nature of the poverty of each family and the neighborhood in which each lives, the consultant must be sensitive to the attitude

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of the staff toward each family. If staff members are annoyed with or resentful of families that "disgrace the neighborhood," the consultant must help them find each family's capacity for change and develop respect for each family's positive qualities.

Focus on each child

The consultant will also need to think about the special and different kinds of strength, the gaps in experience and development, and the vulnerable spots in each child from each kind of family. For instance, children whose fathers are in prison may have intense conflicts about the law and the police, about right and wrong. The normal child of an inadequate mother may find it hard to develop a normal identification with her. Children from poverty-stricken homes may be loved or unloved, may be emotionally overstimulated or deprived, may be anxious or easy-going. In other words, they will have at least as wide a range of differences as middle class children. In addition, children from different cultural groups such as Mexican-American or Puerto Rican may have still different needs.

The consultant will try to help the staff evaluate the needs to determine the most urgent and those that present the greatest difficulty to their understanding and the steps that will most likely lead to progress toward understanding.

The consultant can stimulate the staff to be more observant, show them the value and meaning of their own observations, and help them integrate each other's observations. This process will increase the staff members' respect for the children and their own understanding of the children and will help them identify with the consultant who respects them. In turn, they will be readier to respect each other and the children.

Children of incapacitated, retarded, or mentally ill parents have a wide range of needs and difficulties in development. It is hardly possible to know which of them will respond quickly to the center's care. The disorganized behavior of some may be due to lack of organization or opportunity to learn in the home. Some children are transformed by a few months, or even a few weeks, of regular meals, good food, and guided work and play. Others—battered children, children with disturbed parents—may constantly bring to the center anxiety and anger that interfere with their ability to concentrate at play and work. Still others are hampered by combinations of different kinds of vulnerability—extreme autonomic reactivity in combination with unusual sensitivity to sensory stimulation or hyperactivity. Or they may have extreme susceptibility to infection accompanied by frequent irritability.

When children do not respond to the center's efforts within a few months—when they continue to be hyperactive, disorganized, aggressive, disruptive, seclusive, withdrawn, or timid—they need special attention. Depending on time and resources available, the consultant can make specific observations regarding contributing factors in the child and in his home. He may suggest that the child undergo a comprehensive pediatric examination before a psychiatric evaluation is undertaken. The referral itself, however, should be made by the director.

Program content

The day-care center will probably expect the consultant on child development to make suggestions concerning the content of its program, and he may be tempted to use his broad experience to do so freely. However, it is extremely important for him not to overstep the director's responsibility. Consequently, any suggestions he gives had best come in a discussion led by the director and, perhaps, after consultation with the director about the kinds of suggestions that would best support her ideas.

The consultant often brings to his job a perspective based on intermittent visits to the center in contrast to the director's day-by-day perspective. He may notice problems overlooked by the director and the staff—awkward, frustrating *transitions* from one activity to another; *fatigue* and *excessive hunger* before meals, particularly in the youngest children; *difficulty in settling* down at naptime; *odd behavior* at the beginning and the end of the day. He can help the staff handle "Monday" problems—problems that arise on Monday and not on other days because the children's activities have shifted from home to the center. The consultant can become sensitive to restlessness and other indications of need for new stimulation during periods of long confinement because of bad weather. He may also become alert to overstimulation during exciting celebrations—times that may be so satisfying to the staff they do not notice over-excitement or fatigue in the children.

The director may welcome support from the consultant in his belief that the children need an extra amount of mothering and help, something the staff hesitates to give for fear of "spoiling" the children. She may also welcome the consultant's advice on how

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to add variety to the program when it seems monotonous because the staff cannot offer the special activities afforded by holidays like Thanksgiving and Christmas. From the perspective of a periodic fresh look at the program, the consultant can see individual problems missed by the director and the staff in day-by-day activities such as the tendency of some children to get hungry and tired sooner than others or to need less sleep than others. He may suggest to the director that the center provide extra snack times for those who get hungry early and quiet time activities while others sleep for the wide-awake child.

The consultant may also become aware of conditions contributing to aggressive behavior such as space arrangements that do not prevent children from interrupting or destroying each other's work and, if so, can point out such problems to the director. He can support the director in encouraging the staff to provide restitutive mothering for deprived children and to try out new activities or to provide enough time for individual conversation.

The consultant can also support the director's suggestions to the staff concerning the value of *individual, unstructured play* and *spontaneous, frequent conversation;* of *expressions of interest* in the children's questions, ideas, and achievements; and of allowing the children to *pick the food they like* to develop their capacity for communicating and their awareness of having the power to choose. He can support the director in helping the staff appreciate the gifts of children with different temperaments and from different cultural backgrounds.

Sometimes the staff members of a day-care center want to have only "the best"—the most expensive equipment; new, specially purchased supplies; and so on. They may resent the director's efforts to use what is at hand, to make something out of discarded material, to build equipment, to help the children and their parents cope with available resources. The consultant's authority and experience will lend support to the director's efforts, and he can provide examples of successful use of available resources.

Helping the center reach out to assist parents in taking part in activities in the center and community is another aim of the consultant on child development. Both trained and untrained workers may hesitate to deal with parents because they are afraid that if the parents are encouraged to visit the center they may get in the way, upset the children, or be punitive or disruptive. If the parents are shy, the staff may feel "they don't want to be pushed," and will not offer the step-by-step encouragement such parents need to become part of the center and to learn from participation how to help their children. A major task of the consultant may be to help the staff realize that if parents can be led to participate and to become more interested in what contributes to learning, the children will be greatly helped.

Gains for children

What of the consultant's relationship with the children? I believe most children can gain from contacts with the consultant, especially those who have been emotionally deprived because of apathetic, exhausted, ill parents and who lack supportive grandparents. The consultant may occasionally act like a visiting relative—a person aware of the child as an individual who can supply special, recurrent support, appreciation, or even material "surprises." Such a relationship can help extend the child's trust and build in him the expectation of finding good people and friends everywhere.

As to staff members, the consultant on child development to the day-care center for deprived children will be primarily concerned with the release of the potential in each for helping children and each other and with helping them grow in their work. The insecurity of untrained staff members, the misunderstanding or the conflict between them, and their resistance to suggestions concerning ways of handling and teaching children will decrease as they increase their respect for their own capacities and those of their fellow workers. In building up the strength of the staff, the consultant's spontaneous and genuine appreciation of the positive qualities of each member will stimulate each member's appreciation of the other and will make it possible for each to use the work of others in a complementary way. For instance, a staff member talented in music or storytelling can work with several groups besides his own by "trading" groups for short periods.

Using this approach, methods of teaching, disciplining, conducting play, and handling feeding, sleep, and other routine activities can be refined through discussions between the staff and the consultant from which convictions emerge—convictions based on honest thought about the needs and responses of each child in each group. Beyond this, the staff will have learned with the consultant's help not only "what to do," but also *how to think constructively* about ways of assisting in the development of each child.

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how a large rural State is stretching and improving its services to people through . . . . .

AREA SOCIAL SERVICE CENTERS

T. N. TANGEDAHL

Persons responsible for the quality of public welfare programs have been urgently pressed during the past 5 years to respond more effectively to the acute and chronic social problems that keep many people dependent and threaten the well-being of children. Behind the pressure are the Public Welfare Amendments of 1962, requiring that by 1975 a full array of social services, manned by professionally qualified persons, be accessible to families in all parts of the State. The amendments require that such services not only deal with the problems presented by family breakdown and dependency but also reach out to help families and children threatened with such problems.

For predominantly rural States like North Dakota, where both financial and professional resources are scarce, this assignment has presented public welfare departments with a formidable administrative challenge. Some aspects of the 1967 amendments to the Social Security Act [1] will make the task even more difficult, but the 1962 mandate remains.

One method the Public Welfare Board of North Dakota has devised to meet this challenge is the development of eight State-administered area social service centers, which together cover the entire State. These area social service centers cannot alone meet all the needs for service in the State, but they are definitely improving both the quality and accessibility of such services throughout the State. They are doing this not only by filling the gaps in the direct services themselves but also by providing county welfare agencies and other agencies in the area with the kinds of service that can help them improve their own programs.

North Dakota has a population of 650,000 people and an area of 70,665 square miles. It contains 53 counties varying in size from 635 to 2,735 square miles and in population from 1,200 to over 70,000 people. In 1966, it ranked 40th among the 50 States in per capita income.[2] Nevertheless, that year, according to figures compiled by the U.S. Department of Health, Education, and Welfare, it ranked fifth in average assistance payments made to families with dependent children in December, 14th in its expenditure during the year per child for child welfare services, and second in the proportion of children in the State receiving services under the child welfare program in March. Social services, however, vary greatly among the counties due to variations in economic resources, in adequacy of the staff, and in size of the county areas and populations.

Background

Ever since the passage of the Social Security Act in 1935, the public welfare program in North Dakota has been administered by the counties and supervised by the State. Fifty-three local units of government with such variation in population size considerably strain both administration and supervision. Furthermore, tax-exempt Indian reservations have reduced the tax base of the very counties that most need revenue to support social programs to help people who are living in poverty.

For many years, the Public Welfare Board of North Dakota has struggled with the problem of devising an administrative structure that would make better public welfare services available within the

State's existing legal framework and limited resources. It has employed professional social workers and psychologists to provide consultant services to the counties. With the use of State and Federal child welfare services funds, it has helped Cass County, which contains Fargo, the State's largest city, establish a Children's Social Service Center staffed by a multidisciplinary team of social workers, psychologists, and a consultant psychiatrist to deal directly with the problems of families and children. Through the use of State and Federal funds available through the programs of both child welfare services and aid to families with dependent children, it has helped other counties employ professionally trained child welfare workers or other casework staff. In many of the State's rural counties, however, the staff of the local welfare agency still consists only of a director-worker or perhaps of a director and an agency-trained caseworker to provide both child welfare services and assistance.

The area plan

In 1958, the Public Welfare Board began to discuss the possibility of using an area approach to provide services. The idea received impetus from a study on juvenile delinquency conducted for the Board in 1959.[3] A plan for area child welfare and youth services was put in operation in 1960. The congressional mandate to make services available throughout the State by 1975 stimulated the Board to broaden the concern of the area social service centers to include all public welfare programs—public assistance and medical, as well as child welfare services. This was achieved in 1965.

Under the area approach, North Dakota has been divided into eight areas and a social service center established in the major city of each area. The eight cities with such centers are approximately 100 miles apart. The size of each area was largely determined by the natural drawing power of each of these cities as a transportation, commercial, educational, and medical center. Consequently, one service area includes three counties with a combined population of 35,800; another area, 10 counties with a population of 106,800; and another, six counties with a population of 110,600. To prevent counties from being divided between two centers, county lines were followed in establishing service area boundaries. The area centers are located in modern facilities with adequate space for play therapy, psychological testing, and privacy for interviewing and case conferences.

Under the area social service system, county welfare agencies in North Dakota administer all assistance programs and provide social services to the extent that their financial and staff resources permit, but supervision and consultation are provided them by the area centers. Direct services needed by families in counties with few resources are provided by the area centers, but in general the county welfare agencies are relied upon to make home visits and social studies and to provide certain followup services.

In addition to providing supervision, consultation, and direct services, the area centers help the county welfare agencies with inservice training and staff recruitment. One objective is to establish and maintain within the area a pool of newly recruited workers in training who can be placed where most needed.

The minimum staff of each area center includes an area administrator, a program supervisor, a child welfare consultant or a social casework supervisior or both, a psychologist, and caseworkers. Each center also has a psychiatrist available on a fee-for-service basis. The administrators, social work supervisors, and child welfare consultants all have master's degrees in social work as well as public welfare experience.

Area center administrators have an overall responsibility for the administration of services and programs within the area as well as supervision of the area center staff.

The program supervisors have primary responsibility for the quality of the federally aided categorical assistance programs, medical care for the medically indigent, crippled children's services (in North Dakota administered by the Public Welfare Board), the food stamp program, and the public welfare aspects of civil defense.

The consultants work with the county welfare agencies, the courts, the schools, and other agencies on a case-by-case basis—providing psychological evaluations, diagnostic interviews, and social studies. They also provide direct treatment services to families and children when other resources are not available.

Some of the area centers have advisory councils, usually composed of community leaders representing various disciplines or interests. All eight centers are expected to have such councils eventually. The use of these advisory groups by the centers and the centers' offer of services to people regardless of their financial condition, age, or residence are together changing the negative image of public welfare among many persons in the State.

The direct services provided by the centers are based on the recognition of the environmental, physical, and emotional factors that contribute to dependency, delinquency, or other aspects of social maladjustment. They generally relate to emotional disturbance, mental retardation, parent-child conflict, delinquency, and family breakdown. Marital counseling is being emphasized to protect children from the shattering experience of family breakdown.

A social worker usually carries the major responsibility for each case and calls on the psychologist for psychological testing when appropriate and on psychiatric and medical consultants when needed in making decisions. Cases requiring medical or psychiatric treatment are referred to appropriate public or private facilities. Family physicians are consulted early in the intake process. A medical report and a social study are prerequisites for providing a psychological examination. The program of crippled children's services is frequently called upon for a diagnostic examination of children or others under 21 years of age when a physical basis for retardation or unusual behavior is suspected.

Thus far most referrals to the centers for direct services have come from the courts, county welfare boards, and the schools, but referrals from physicians and clergymen are steadily increasing as are self-referrals.

Some county welfare boards, fearing a State takeover of their prerogatives, at first resisted the establishment of the area centers, but such resistance was not extensive and has subsided. It came chiefly from counties with the largest populations and most resources. In the more rural counties, the local welfare boards have generally looked upon the centers with favor because they have provided the specialized services these counties have been unable to provide. From the beginning the State welfare department has directed the centers to encourage the development and coordination of local services within each area.

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As county welfare services become more self-sufficient, the area centers will give more time to program supervision, consultation, staff development, and coordination. The goal is mutual reinforcement through coordination of effort.

The centers

Sometimes a program may be viewed with more objectivity and better perspective by someone from the outside than by one closely involved in its establishment. North Dakota was fortunate in having Hobart A. Burch, a representative of the U.S. Department of Health, Education, and Welfare, visit the State to observe the operation of the area centers. Dr. Burch visited two area social service centers and then interviewed staff members of the other centers. To avoid repetition, he reported in detail on the Minot area social service center and only on variations in the other seven centers. With some condensation, a few minor additions, and updating, the following description of the area social service centers was borrowed from Dr. Burch's report:

The Minot area includes seven counties with a population of 123,000—including the 20,000 persons on an Air Force base outside the city of Minot, many of whom are served by the Minot area social service center. Minot, where the area center is located, has a population of about 35,000 and is one of four "large" cities in the State. Agencies in the area include special education departments in the county and city school systems, a mental health and retardation unit, a probation and parole office, a district office of the State employment service, a speech and hearing clinic, an alcoholic information center, and Red Cross, YMCA, and YWCA agencies, all located in Minot. The area extends into two judicial districts. Three district judges, who also serve as juvenile court judges, live in the area.

The staff of the Minot area social service center includes an area administrator, a program supervisor, a psychologist, a social work supervisor, a child welfare consultant, a case aide, and two secretary-receptionists. The administrator, the social work supervisor, and the child welfare consultant earned master's degrees in social work under the stipend program of the Public Welfare Board. The psychologist is completing final requirements for a Ph. D. The case aide came to the staff directly on graduation from college. A psychiatrist spends 2 days a month at the center as a consultant. In addition, the center secures pediatric consultation, as needed, and some

further psychiatric consultation and psychometric testing on a fee-for-service basis from professional persons who live in the area.

The social workers, the staff psychologist, and the consultants function as a team for treatment, consultation, and community relations. The case aide has gradually been given increasing responsibilities on a selected basis as she has developed capacity for carrying out more complex tasks such as intake interviewing, serving as a liaison person with schools, conducting therapy, and providing casework services to children and families.

The first step of the area administrator and consultants when assigned to the newly established center was to become acquainted with the leaders and resources in the areas. They met with the two judges about the needs of juvenile offenders, neglected children, and families in trouble. They conferred with the superintendents of schools and with classroom teachers to find out how the center's program might be constructed to meet social needs as seen by educators. They conferred with the local directors of the State employment service to learn how the center and the employment services could work together to meet families' needs. They consulted with the director of the local vocational rehabilitation office, and they continue to have regularly scheduled meetings. They talked to doctors and clergymen. They spoke to civic clubs, church groups, and PTA's and made note of what the members of the groups said to them.

The next step was to establish a local advisory committee consisting of two juvenile court judges whose jurisdictions are in the area; a newspaper columnist; the owner of a radio and television station; the chairman of the social welfare committee in the legislature; an attorney; a county director of special education; a junior high school principal; a parochial high school principal; the dean of women at the local college; and a pediatrician. This committee has been active both in shaping the program and interpreting it to the community, often reaching or influencing persons and groups not readily accessible to the staff. It has taken part in major policy decisions such as the rejection of a suggestion that a fee schedule be set up for persons able to pay for the center's services.

Although the area center is part of a State-administered program receiving substantial Federal support, the committee and the community look on the center as a *local* agency. Its program has been shaped to meet the needs of the schools and the courts though it also serves people who come for service on their own, providing them with casework treatment or counseling or referral to other resources as indicated. The Minot center, like other centers, includes a play therapy room with a one-way observation window to permit staff members as well as the staff members of referring agencies in staff development programs to observe counseling techniques and casework treatment.

The bulk of this center's activities thus far has consisted of service to specific families and children through direct social diagnosis and casework treatment or through providing county welfare departments, courts, schools, and other agencies with psychological evaluations, casework and psychiatric consultations, and social studies. The center has also held workshops for the staffs of county welfare agencies and for policemen, sheriffs, and clergymen throughout the area. Its ultimate goal is to improve the quality and build up the kinds of resources in the area.

Variations on a theme

Each area social service center has been given the freedom to adapt its program to local circumstances and to the ideas of its staff. The State office provides the centers with supervision, support, and professional guidance but does not prescribe the local program. Local variation is regarded as desirable. Therefore, emphases in the areas vary.

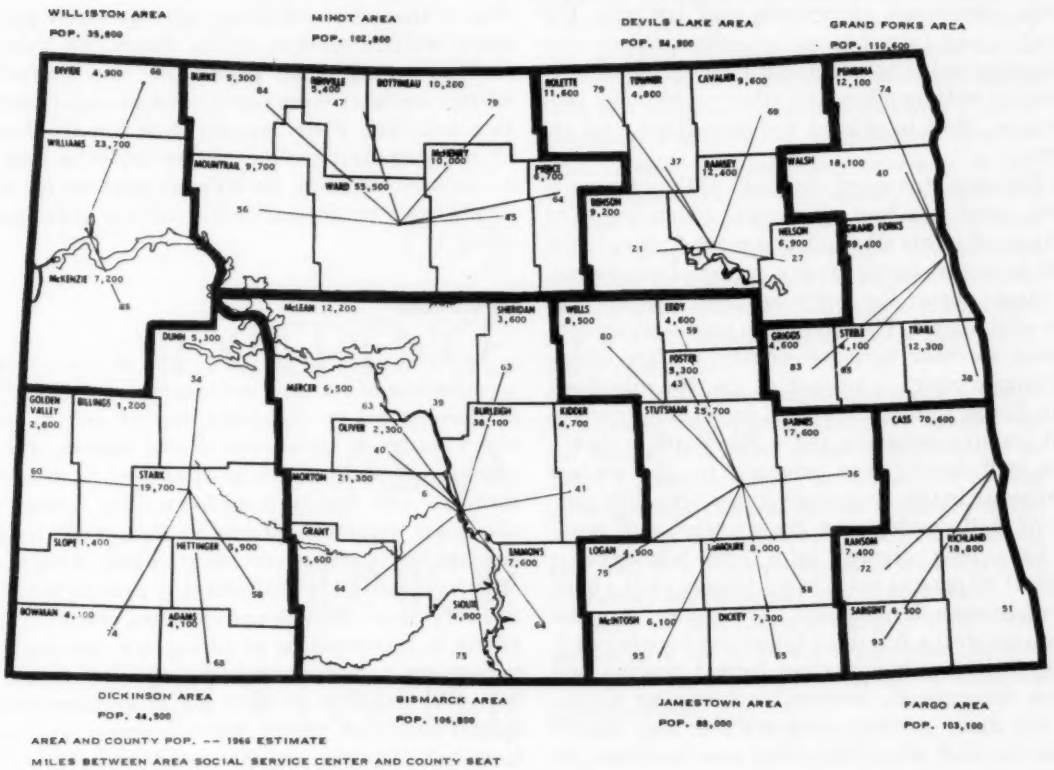
In the Devils Lake area, for example, emphasis is on improving the helping ability of county welfare agencies and other local resources through staff development and consultation services. The area center provides direct services only on a gap-filling basis. Because some of the greatest unmet needs in this area are among children on Indian reservations, the center's staff is building up cooperative relationships with the Bureau of Indian Affairs.

The Williston area social service center has worked closely on a consultation basis with the schools and the court and with local physicians and ministers. It has also developed a groupwork program for adolescents, using facilities provided by local businessmen and service clubs and leadership provided by members of the center's staff who volunteer time in the evening and on weekends. This center experimented with placing some staff members in outposts to provide direct service, but it ran into problems of staff morale and supervision. It is now working to develop the service capacity of the county welfare offices.

In the Jamestown area the administrator of the

AREA SOCIAL SERVICE CENTERS

Public Welfare Board of North Dakota



AREA AND COUNTY POP. -- 1966 ESTIMATE

MILES BETWEEN AREA SOCIAL SERVICE CENTER AND COUNTY SEAT

social service center has organized the welfare directors of the nine counties in the area to plan together for strengthening their services. Each member of the center's staff has been assigned certain counties for intensive consultative service, adapted to the understanding and competence of the local workers. The center places emphasis on direct services to families and children referred from county welfare offices. This area center has departed from public welfare's traditional defensive stance in public relations to "advertise the good things" of public welfare—its resources to help people. Its attractive, modern office should stimulate the movement toward better quarters for county welfare offices.

The Grand Forks area social service center began its activities by concentrating on developing the service capacity of the two largest county welfare offices in the area. It provided 6 months of intensive supervision to county welfare caseworkers, part of which was spent in the center.

At first the Grand Forks center offered no direct services other than psychological evaluations and consultation to other agencies. It now provides direct treatment services to children and families referred for help from schools and other agencies, especially the family court. Consultation is given priority in allocating the center's staff time. The center maintains a close relationship with a nearby Air Force base with a population of approximately 17,000 persons, as well as with a number of local agencies, including day-care centers, sheltered workshops, and a mental health and retardation service unit in Grand Forks.

The Dickinson area social service center serves a sparsely populated area known as the Badlands. Because local services in this area are scarce, direct serv-

ices to families and children play a more significant role in the center's program than in other centers. Referrals come most often from school and court officials, physicians, clergymen, and lawyers. The center has found itself facing a demand that exceeds its capacity and is now increasing its consultation to the county welfare offices and other professional persons in an effort to expand and strengthen local resources.

In Bismarck, the major emphasis of the area social service center has been on marital counseling. The family court refers all applications for divorce to the center for a mandatory 60-day period of counseling. The supervisor of the center has been appointed as officer of the court. The center also provides case consultation to other agencies—county welfare offices, the juvenile court, a project of the Neighborhood Youth Corps, Catholic Welfare, an MDTA prevocational training program, and a Headstart project—and a staff development program for the welfare departments in the 10 counties in the area. For purposes of staff development, the counties' staff members have been divided into three homogeneous groups of 10 persons each, based largely on the level of professional development. The center provides each group with a full day of inservice training each month. This training involves formal reading and writing assignments, lectures, and seminar discussion, but many workers come early or stay late to consult the staff about individual case problems. As a complement to this program, the center is stepping up its evaluation and consultation services to the county welfare agencies.

The Fargo area center similarly provides consultation, staff development, and direct casework services. It alone, however, provides a program of financial assistance to unmarried mothers, using Federal funds available through the program of aid to families with dependent children and the State's foster care program. Referrals may come from the county welfare boards through the maternity homes in Fargo or directly from the maternity homes and other voluntary agencies. This program makes it possible to help women and girls who do not wish their pregnancy to become known to persons in their home counties.

The Public Welfare Board of North Dakota regards the system of area social service centers as a means of preserving local county welfare operations and at the same time achieving greater coordination and accessibility of services, encouraging local initiative, and providing a broader financial base for services. While most of the area centers have been spending the bulk of their effort on the provision of direct services to people, the State department is making it clear to the counties that they are expected to provide better welfare services in the future. To this end, counties having small populations and limited resources are being encouraged to consolidate their welfare activities. Four counties have already done so by merging their public welfare activities into two administrative units. An ultimate goal for the State might be 25 or 30 local public welfare units instead of 53.

Future role

As more services are developed in the counties, a major role of the area social service centers will be to develop public understanding of and so bring about change in the environmental factors, both social and physical, which so often lead to emotional problems and family breakdown. The centers will also place greater emphasis on their staff development and consultative services to county welfare and other agencies. They will probably provide fewer direct services to families and children, reserving their efforts in this direction to filling in remaining gaps in services and demonstrating the importance of using the resources of other public agencies such as special education, public health nursing, and vocational rehabilitation and the special services provided by the employment service and the courts, as well as by churches and other voluntary agencies. They may also experiment more widely with groupwork as a method of treatment.

A system of area social service centers, as developed in North Dakota, is certainly not the only way of meeting the requirements of the Public Welfare Amendments of 1962 nor does it represent a solution to all the public welfare problems in North Dakota. It does, however, represent North Dakota's attempt to coordinate the efforts of all resources in the State to meet the requirements by the 1975 deadline. More important, it represents the effort of a rural, sparsely populated State with very limited resources to make life better and more productive for families and for children.

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[1] Public Law 90–248. [See *Children*, March–April 1968, page 79.]

[2] U.S. Department of Commerce, Office of Business Economics. *Survey of Current Business*, August 1967.

[3] Hoadley, Mildred; Gardebring, Olov G.: Imperiled youth. Public Welfare Board of North Dakota, Bismarck. 1960.

MY EXPERIENCE AS A JUNIOR VOLUNTEER

The following description of a 16-year-old girl's experience as a junior volunteer at the Happy Hills Hospital in Baltimore, Md., is based on the report she prepared for her supervisor. Happy Hills is a nonprofit voluntary pediatric hospital providing long-term or convalescent care for children with physical injury or illness. It regularly uses junior volunteers, usually young people of high school age, to work with children especially needing individual attention. Selected from applicants by a member of the hospital's Women Auxiliary, the volunteers work under the supervision of the Nursing Service and a director of junior volunteers.

Tommy, the young patient who was assigned to Miss Levine, suffers from hypoglycemia, and this has resulted in a severe speech defect. He was selected for the volunteer's attention both because of his own needs and because his behavior was disruptive to group activities. He is now adjusting very well in a foster home under the auspices of the Family and Children's Aid of Baltimore.

"Andi," as Miss Levine's friends at Happy Hills call her, will not be back at the hospital this summer. Now 17, she is going on an archeological dig in England.

ANDREA LEVINE

Early in the summer of 1967, I looked for a paying job until I had exhausted every possible means of obtaining one. The only real offer I had was to babysit for a 5-year-old, and I decided that I would rather die than stay with one small child for the whole summer. So it was really a last resort that brought me to the Happy Hills Hospital as a junior volunteer.

When I came out to register I was determined to make what could have easily been a twice a week volunteer stint into a full-time job with some value. I had never liked children very much, but since they had always taken to me quite well, I felt that I could do them no harm. When I was told that I would be allowed to work with a 4-year-old problem child with a

speech defect, my spirit of adventure was ignited and the job no longer seemed dull.

I met Tommy, my charge, that very day. Tommy is a very handsome little boy to whom you can endear yourself right away. When I had him out on the playground, I thought to myself, "He's no problem; these people must not treat him right." About the same time that I was thinking that, I noticed it was time to come in. When I proceeded to tell Tommy this, he had such a tantrum that I began wondering why they didn't keep him behind bars.

Not only was Tommy's behavior problem greater than I had thought, but so was his speech trouble. In an effort to help him, I went to the library and took out all the books I could get on speech therapy and read them from cover to cover.

For the next 2 weeks, Tommy and I tested each other on just how far the other would go without breaking. By the middle of July, we knew each other quite well and began to develop the first strings of an emotional involvement. For example, Tommy felt I was his property and no one else could have me. I became terribly protective of him. Whatever happened, it just wasn't Tommy's fault.

My attempts at speech therapy turned out to be games in which Tommy learned the correct pronunciation of all the consonants and letter combinations. By the end of the summer, he could pronounce them well, but he still could not see that the same sounds he made in a game should be used in his everyday speech. Although his actual speech was not much clearer than it was when I began working with him, his vocabulary had increased considerably.

In August, a social worker came to talk with Tommy about a foster home. She couldn't understand him at all and so, because I was so proficient, she invited me in. I watched her deal with him and began to see how far he and I had come in learning to communicate with one another. The social worker asked me to try to explain to Tommy that he was going to have a new mommy and daddy. Later Tommy and I talked about it a few times, and he seemed to understand as well as he could for not as yet having met his new family.

One day late in August, I took Tommy to the psychologist at the Sinai Hospital. The psychologist couldn't understand him, so he asked me to come in. The psychologist tried hard to get through to Tommy, asking him all sorts of questions to which I knew Tommy knew the answers, but Tommy was far more interested in the alarm clock and tape recorder than in listening to anyone! But I held my tongue until the psychologist showed Tommy a wagon with a wheel missing and tried to coax him into saying something about it. I just could not be quiet any longer, so I yelled: "Tommy, what's wrong with that wagon?" Tommy looked at me as though I were sick and answered as plain as day, "The wheel's broken."

I think the worst day I had at Happy Hills was the day I came to work just in time to see my Tommy get into a car with his new foster parents. It is rather hard to believe that Tommy isn't really mine and that all I did was to make it easier for him to enter a family. I suppose that that was worthwhile.

I'll miss Tommy a great deal. But I have other ties at Happy Hills. I know all the children there. I've made a lot of friends, and, more important, I've discovered that I can deal with children successfully.

I've always wanted to go into the field of psychology, but I never knew what branch. After last summer's activity, I think I just might have a go at abnormal child psychology. And if I'm successful, I think I'll come back to Happy Hills and do another summer's worth of volunteer work.

a State mental hospital uses . . .

PUBLIC INFORMATION PANELS

as THERAPY for DISTURBED YOUNG PATIENTS

DONALD R. DIXON ● CARL M. ROWLEY

Young people at the Utah State Hospital for the mentally ill at Provo serve themselves, the hospital, and the public through a "public relations" program sponsored by the hospital's Youth Center. As members of panels answering questions about the hospital's program for children and young people before visitors to the hospital or before civic, social, and educational groups outside the hospital, the young people receive therapy, the hospital explains its program and policy to the public, and the public learns much about mental illness and how the hospital is helping troubled young people.

For many years the Utah State Hospital, erected in the 1880's, meant to the citizens of the State the "insane asylum" or the "crazy house on the hill." The hospital served the State, to a large degree, as a receptacle for people who were social failures or misfits. And for a long time the State and the community seemed content for the hospital to perform that function only.

In the early 1950's, however, significant changes began to take place. Hospital administrators introduced group therapy as a treatment method for all patients, "back" wards were abolished, and every ward or unit was given responsibility for admission and discharge. Ideas about community therapy were introduced. They soon flourished and, in time, greatly changed the atmosphere of the hospital and its potential for treatment. The psychopharmaceutical compounds, introduced at about the same time, also made great contributions to treatment.

Such changes seemed to awaken community interest in the hospital and an awareness in its staff of an obligation to inform and instruct the public about the changes in its program and policy. Consequently, during the past 10 years the hospital has thrown open its doors to the public, and every year from two to three thousand persons visit it. To make their visit worthwhile, hospital staff members have used various methods of showing the visitor around the hospital and of explaining its program and policy. Perhaps the most successful methods have been the guided tour led by patients and the panel presentations during which patients answer questions about the hospital and the treatment they are receiving put to them by a moderator from the hospital's staff or by the visitors themselves.[1]

On invitation, patients and moderators have gone into the community to give panel presentations to high schools, colleges, service clubs, and religious or-

ganizations. During school year 1966–67, for instance, 126 adult panel presentations were made outside the hospital in all areas of the State.[2] Audiences and patient participants have both testified to the benefits of these efforts.[3]

The Youth Center

The Youth Center at Utah State Hospital is the State's only residential treatment center serving young people throughout the State, 18 years of age and under. Its purpose is to meet the needs of psychotic or seriously emotionally disturbed young people. The Youth Center has departed from some of the treatment methods usually associated with residential treatment centers throughout the country. Basically, the program emphasizes social processes and forces as the therapeutic medium and has departed from the doctor-patient relationship in favor of team-patient relationship. The hospital emphasizes aspects of the environment, opportunities for responsibility, group and peer dynamics, confrontation, expectation, and here and now events as the principle therapeutic exchange. Vigorous social work and family therapy are important, as is diagnosing disease and evaluating good points and trying to make the most of them.[4] The staff of the center has tried to use what has happened at the Utah State Hospital to find a place for children in its efforts.

Since it was set up in March 1964, the center has treated about 380 children and young people. Its staff has found that both lay and professional people are interested in the program. In fact, the hospital has been flooded with requests for permission to visit the Youth Center and for speakers to appear before various groups to discuss the program.

Because of the success of the adult panel presentations as a way of informing the public about the hospital's work and as a therapeutic medium for the patient, the Youth Center when it began set up a similar program for young people and has sponsored panel presentations on its work. The staff originally used the panel presentations as a way to explain the program, but soon found that the presentations could also be used to help patients. The public's reception of the presentations and its demand for them exceeded expectations. The young participants have, for the most part, been enthusiastic about taking part and have supported the staff in this endeavor.

Though presentations are not all alike and differ as the personalities of the panel members and the panel moderator differ, a certain basic method seems to produce the best results. A panel of four or five young people, mostly of high school age, seems to be ideal. The staff member who will serve as moderator selects the participants with an eye to the purpose of the assignment, the ability of the young persons to work together, and the readiness of each to take part in this activity.

All participation is voluntary, and any young person who wishes may take part. Most have several opportunities to appear on panels during their stay in the hospital. The moderator tries to include both aggressive and passive, both new and old patients. Though many patients are able to take part even in their first week of hospitalization, patients who are acutely ill are not considered immediately. The center makes a special effort to include withdrawn patients. Although they are often frightened at first, many of them have benefited from participation. No young person serves on a panel unless his parents have signed a release-of-responsibility form, requested at the time of admission. Very few parents have refused to allow their children to take part.

There are no "set" panels. Each is organized when a request for a presentation is received. The makeup and size of the audience, where the presentation is to be made, and the balance of the panel are taken into consideration.

Panel discussions

As each audience is interested in different kinds of information, before a panel presentation is made, staff members draw up a list of questions appropriate to the situation. For instance, if the presentation is to be made to a group of public high school students, the questions might include these: As many of you have had serious difficulty in school before coming to the Youth Center, what are some of the things public schools could do to improve their programs? Why do teenagers seem to have trouble communicating with adults, including their parents? Do you have any advice to give the audience as to how they could avoid problems similar to your own?

The questions often reflect the interest of staff members in the young people's feelings and attitude toward such varied subjects as discipline, authority, education outside the hospital, goals, and family problems. Personal information is treated generally or superficially only. The young people are free to answer as they wish and need not answer a question if they do not want to. The moderator encourages the audience to take part and allows time either during

or just after the panel presentation for questions from the floor. The presentations are held in a variety of places, and the size of the audiences varies. They may be given in an auditorium or in a classroom. Sometimes classes or other groups come to the center. Questions are usually put direct to the panel participants. The moderator allows the question if it is appropriate. If it is not or the young person appears uncomfortable about answering it, he diverts the question or indicates tactfully that it is not an allowable question.

One of the primary reasons the hospital uses panel presentations is to provide information about the Youth Center to both professional and lay people. Many community groups, schools, and agencies have invited panels to discuss the program. The hospital staff has found that reception is better and interest greater if the young people rather than staff members give the presentation. The young people have proved that they can discuss the various aspects of the center's program and life at the hospital realistically and authentically. Audiences are usually impressed with the way the young people act. Many people, expecting hospital patients to act bizarrely, are impressed with the ordinary behavior of the young people from the center, and they often comment on how similar these young people are to those in the community.

Since the center began using the panel presentations, it has received more and more requests for them. The demand has grown so great the center estimates that a panel presentation is made every week either in the hospital or in the community. More and more people are becoming acquainted with the program, and opportunities are expanding to inform the public about the problems of mental illness in children and young people.

Patients' views

Many young people in the hospital appear to enjoy being on panels. To get more specific information concerning their attitude toward and feelings about the panel presentations, staff members recently drew up a questionnaire about the panel presentations and administered it to all the high school students in the center.

The questions centered on participation, interest and enjoyment, and the advantages and disadvantages of the panel presentations as the young people saw them. Thirty-one of 37 young people completed the questionnaire. Those not responding were either

Both Donald R. Dixon, left, and Carl M. Rowley are psychiatric social workers in the youth program at the Utah State Hospital and part-time instructors in the undergraduate social work program at Brigham Young University. They hold master's degrees in social work from the University of Utah, where Mr. Rowley is a field instructor.

new patients or were not available at the time the questionnaire was administered.

As to *participation*, about 19 had been on at least one panel and many had been on three or more.

As to *interest* and *enjoyment*, half of the young people who had not taken part said that they were interested in the panels and only three of those who had taken part said they had not enjoyed the experience. The comments of many of them were enthusiastic.

A 16-year-old boy said: "Well, I really like to get out and meet people and see what the high schools are like, and also I come back with a better attitude. I really do like to go on panels." Another 15-year-old boy said: "I think it helps you understand the other kinds, and it's fun."

As to *advantages* and *disadvantages*, for the most part the young people saw advantages. A 15-year-old girl said: "It helps the public to change the picture that it has of the hospital. It helps people to learn from our mistakes." A 17-year-old boy said: "It gives me a good feeling to be able in my own small way to let the people that we talk to as a panel know about the help at the Youth Center. I think panels are the most effective way to raise the public image of the hospital in general." Another boy of 17 made this comment: "Many misconceptions are held by people on the outside about the patients here at the hospital. These panels help to iron out these misconceptions. Also it helps me to know that the people at the panels at least partly accept me." But one 15-year-old girl said: "It isn't always easy to get up in front of a group of people you don't know and talk about your problems. Sometimes they don't understand." Another girl said: "Panels are phony, and you are forced to say too many things."

The young people typically express commitment to social standards whenever they discuss their problems and the Youth Center program, but never more so than during the panel discussions. They take the

responsibility seriously, and during a panel presentation seem more capable of insight and good judgment than at any other time. They internalize some of this commitment. Though there are exceptions—to be discussed further on—most experience has been constructive. The staff has great respect for the young people's ability to act as ambassadors for the center.

Some benefits

Relations between staff members and young people are often improved through this activity. As panel presentations are often given at some distance from the center, travel time to and from the event offers an informal opportunity to discuss feelings, attitudes, and problems. The young people seem to take pride in making a good panel presentation, and the staff's confidence, faith, and approval seem to gratify their ego.

Another apparent benefit to the young people is the personal development that often takes place. Speaking in front of a large group of people seems to help them develop a sense of accomplishment, self-confidence, and poise. The staff has noticed a great change in the young people's ability to speak in front of groups after they have taken part in several presentations. After every presentation, all participants seem satisfied, and the audience seems rewarded by and interested in what has taken place. Many of the young people are experts on the subject of the center's program and both the panel moderator and the audience recognize them as such. This recognition is gratifying to the young people, and it tends to reinforce socially acceptable attitudes and behavior.

The case of one girl, 16-year-old Sara, illustrates how one patient was helped to improve and progress while in the hospital by taking part in a panel presentation. Sara had come to the center with many serious problems, including withdrawal and inability to relate socially to other people. She had very low self-esteem and lacked confidence in meeting and dealing effectively with other people. These characteristics greatly influenced her adjustment to school work, and she was unable to tolerate being in a regular classroom because of the demands made on her to relate to other students and a teacher. She ran away from class from time to time and committed antisocial acts.

After admission to the hospital, Sara's behavior followed the same pattern. However, in an institution, she did not have the power to boycott activities involving other people. After she had been in the hospital some time, Sara agreed to take part in a panel presentation even though she was frightened at the thought of speaking in front of other people. Her determination to overcome her problems seemed to have been vital in influencing her to agree to participate.

On the panel she did an excellent job, considering her background. Sensing the audience's interest and warmth, she became more at ease as the presentation went on. When the presentation was over, she appeared satisfied with the experience and immediately inquired about future panels. Experience like this helped her develop self-confidence and raise her self-esteem. She continues to have some problems in establishing relations with others but has improved to the point that she has been able to leave the hospital, obtain full-time employment, and conduct herself appropriately.

Sara's case is only one of several examples that could be given of the therapeutic benefits that come to some of the center's young people from taking part in panel presentations.

And shortcomings

The results of the panel presentations are not all good, the center's staff has found. The panels have several serious limitations and cause concern in several respects. The most serious of the shortcomings are the morbid curiosity of the public, the tendency of some young people to give misinformation, the appearance of unhealthy individual and group processes, and the glamorization of the use of drugs.

The public is sometimes morbidly curious about the personal problems of the young people on the panels. At some presentations, audiences have tried to probe into aspects of conditions or treatment in ways damaging to the young people. Such attempts are untherapeutic and embarrassing and detract from the intent of the panel presentation. Many of the young people spoke out strongly against this aspect on the questionnaire.

Occasionally, young people make exaggerated or untrue statements on the panels about the hospital and its youth program. Audiences, of course, bring to the situation their own prejudices and hear what they wish to hear about the hospital. One boy, aware of this tendency in some of the patients, said on the questionnaire: "Since these false ideas do exist, there are a few persons I don't like to see go on a panel because of the possibility of their furthering those ideas.

It gives me a very uncomfortable feeling to know that there are questions they have to ask me that I cannot answer because of a lack of confidence."

The moderator, however, elaborates on or clarifies a young person's answer as necessary. How active he becomes is determined by the group's actions and how factually they interpret the situation they are in.

Some young people become excessively dramatic and theatrical and begin to play parts. They tend to become boisterous, to show off, and to regard themselves as celebrities. Some who are prone to verbal aggressiveness tend to control and dominate the panel and thus to minimize the contributions other panel members might make.

Perhaps the most unfortunate misuse of the panels was one that occurred recently because of the increased number of young people sent to the hospital for drug abuse, most notably LSD, and the public's fascination with and concern over the "hippie scene" and the use of psychedelic drugs. On three occasions, the center sponsored presentations with panels composed primarily of young people whose problems stemmed from the use of drugs. A contagion seem to set in on these occasions as the panelists resorted to "hippie talk," expressed "hippie" attitudes, and affected "hippie" dress. Taking part in the presentations seemed to reinforce their preoccupation with drugs and tended to glamorize their use. Naturally, the audience was curious and asked such questions as "What's a trip like?" At one point, it seemed as though the young people were trying to convert the audience to a belief in the benefits of LSD and the "hippie" movement.

The staff of the Youth Center decided that such a presentation was doing the young people a great disservice and discontinued the "drug panels." Professional staff members, however, have continued to give talks to interested groups regarding the use of drugs as it affects young people. The hospital strongly discourages discussion of hallucinatory experience because such discussion has a contagious effect both on the young people discussing the subject and on other impressionable young people. Rather, it encourages each young person to examine his behavior and to study the choices he has. Though many of these young people are from affluent homes, they lack self-direction, ability to develop and sustain relationships with others, and self-acceptance. Through the use of drugs, they lead themselves to believe that they can find their place and themselves.

The center focuses its treatment on the problems that seem to be at the root of drug use: poor self-image, disturbed family relations, distorted standards. Like most facilities that treat persons who have used drugs abusively, the center is not optimistic about its chances of successful treatment.

More advantages

Despite such shortcomings, a conviction remains with the staff that the panel presentations do attain their goals. They offer therapy to the young people, the hospital explains its program and objectives to the public in a more graphic way than it could otherwise, and the public is learning much about young people with mental illness and what the center is doing to help them.

The staff believes that the advantages of the panel presentations far exceed the disadvantages. Public demand is great, and the interest of the young people is high. The staff believes that it is fitting to capitalize on this opportunity and, in fact, to increase the use of panel presentations.

The comment of one of the boys who had been on a panel sums up the case for keeping the panel presentations going. In replying to the questionnaire, he said: "I can't see any disadvantages in the panel program. I can see that a formal panel could be uncomfortable for both the panel members and the people here. Informal panels are very satisfying to me as a patient. . . ."

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[1] Rowley, C. M.: Visitors to the Utah State Hospital. *Provo Papers*, Fall 1964.

[2] Callahan, N. O.: Patient panels, public relations, and therapy. *Provo Papers*, Spring 1967.

[3] Sexton, Vickie: Can participating on panels help you? *Lodestar* (Utah State Hospital Patient Publication), September 1967.

[4] Faux, E. J.; Dixon, D. R.: Children in the therapeutic community. *Diseases of the Nervous System*, March 1967.

a report from abroad . . .

IMPROVING HOSPITAL CARE FOR CHILDREN

ANN HALES-TOOKE
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When I attended a conference on the hospitalized child in Philadelphia last May (1967), a conference at which the American Association for Child Care in Hospitals was officially instituted, a number of people associated with U.S. hospitals expressed keen interest in Britain's Platt Report on "The Welfare of Children in Hospital"[1] and its provision of a state charter for sick children. Since returning home, I have often had the thought that many people in the United States concerned with the welfare of children, particularly those in hospitals, might like to learn something about this report and about the National Association for the Welfare of Children in Hospital, the British association I represented in Philadelphia.

Issued in 1959, the Platt Report came about as the result of a study conducted on "the arrangements made in hospitals for the welfare of ill children—as distinct from their medical and nursing treatment,"—by a committee headed by Sir Harry Platt, M.D., at the direction of the Central Health Services Council of the Ministry of Health. In the report's introduction, Sir Harry wrote: "It is clear that interest in the subject among parents and hospitals has been growing steadily since we were appointed, and we believe that a movement towards a new concept of child care in hospitals is already well advanced."[4]

Actually, interest in the subject of the child in the hospital had been growing in the nursing and medical professions in the United Kingdom since James Robertson's film, "A Two-Year-Old Goes to Hospital," hit people in these professions like a bombshell in 1952 and exploded the belief they generally held that the child who is "quiet" in the hospital is a "settled," happy child. The film clearly shows what Mr. Robertson calls the three phases of response to separation: protest, despair, and detachment.[2] Mr. Robertson's second film, "Going to Hospital With Mother," released in 1958, shows that it is practical as well as desirable to admit mothers to hospitals with their small children.

Recognition of the small child's need for his mother is fundamental to the Platt Report. This recognition led to the two main recommendations of the report concerning unrestricted visiting: parents should be able to visit their children in the hospital at any reasonable time of day when the child would normally be awake and provision should be made, where possible, for the mother of the preschool, hospitalized child to stay with him as she wishes.

However, concentration on these cardinal points seems to have led many people in the United Kingdom to overlook recommendations in the report aimed at reducing to a minimum mental stress in sick children—such recommendations as the provisions of home-care services, separate casualty admissions for children, minor operations on a 1-day basis (much more common in the United States than in the United Kingdom), and the provision of meaningful occupation for hospitalized children.

The Platt Report was accepted by the Ministry of Health in 1959, and its recommendations have been constantly brought by the government to the attention of the 1,099 hospitals admitting children—with varying degrees of success.

Lay interest in the welfare of hospitalized children grew fast after the publication of the Platt Report. Newspaper articles on the subject, the release of the Robertson films to the public, and the discussion of the films by television panelists brought to the surface a great wave of dissatisfaction with rigid hospital policies and revealed the great unhappiness these policies caused at times to parents and children alike.

In 1961, a group of mothers in Battersea, South London, after seeing the

Robertson films, investigated policies in hospitals in the Battersea area and found the recommendations of the Platt Report were being followed unevenly. After interviews with nurses and physicians about the matter, their leader said later: "We were well received by all the matrons in our area, and they explained that no one had ever said the children were upset when they got home."[3] Under professional guidance, the group carefully collected evidence that some of the small children who had appeared "settled" in the hospital wards, when they returned home, had shown signs of disturbance—they had clung excessively to their mothers, had nightmares, and regressed in toilet training—sometimes for long periods.

Shortly after the mothers talked with the hospital people, *The Guardian* newspaper published a letter from the mothers listing their findings on its influential women's page. This letter brought in hundreds of inquiries to the newspaper. Parents all over the country, having heard of the Platt Report, wanted to have its recommendations carried out in their local hospitals. Overnight, almost, a new voluntary association was formed, which called itself at first the Mother Care for Children in Hospital (MCCH).

A growing movement

The association was formed as a spontaneous expression of informed public opinion that had been gradually crystallizing since the late 1940's. The Children Act of 1948 altered the whole legislative approach to children in residential care. As a result of the act, large institutions were replaced by small family units—cottages and homes. Throughout the 1950's, the research and writings of John Bowlby, D. W. Winnicott, and many others and the Robertson films led to the awakening of the public consciousness to the dangers of maternal deprivation and separation anxiety.

Once launched, MCCH grew fast. In 1965, its name was changed to the National Association for the Welfare of Children in Hospital (NAWCH) and it was registered as a charity by the charity commission for England and Wales. Since then, professional hospital workers and parents have become members in increasing numbers. It now has 58 local groups and about 4,000 members.

In 1966, the Minister of Health, in opening the association's annual conference, said: "I have been most impressed with the sense of responsibility which has governed your association's approach to its objects, a virtue not always found among pressure groups, for that is what you are in the best sense of the word."[4] The Minister was referring, I believe, to the surveys made by the association on "mothers-in" accommodations and conditions and visiting hours in eye wards and in burns, plastic surgery, and isolation units, as well as to visiting facilities in all hospitals admitting children in selected hospital regions.

Policy not practice

Factfinding surveys by the association and discussions between officials and members of the Ministry and hospital staff members all over the United Kingdom have in 7 years altered a great deal the inflexible handling of child patients that had been traditional in the nation's hospitals.

The latest Ministry of Health report for 1966 states that in October 1966, 80 percent of the 1,099 hospitals admitting children no longer restricted visiting hours to parents as compared with 71 percent of the 1,032 hospitals reporting in April 1966.[5] NAWCH, however, contends that the official returns on this and related topics such as mothers-in units tend to be optimistic and reflect, perhaps, the *policy* of a hospital management committee rather than actual ward *practice*.

This contention is supported by the association's own surveys. For these, the association relies on up-to-date information supplied by its members who have either had children recently in hospital units or who have made it their business to talk to ward sisters (head nurses), the persons who ultimately decide how the policy of "unrestricted visiting" is to be interpreted in their wards. Our members have found that interpretation can mean as little as 2 hours—say, from 2 to 4 p.m.!

On January 15 of this year, the association sent the Minister of Health the results of two surveys made in 1965 and 1967 of the treatment children were receiving in ear, nose, and throat wards. These surveys show strikingly discrepancies in practice. Throughout the country visiting is more restricted in this kind of ward than in a general children's ward. Often officials permit no visiting on the day of the operation. Accommodations for mothers are limited. Because of lack of space, children are often nursed in adult wards despite the Platt Report's strong recommendation that this practice should be discontinued as harmful to a child's morale.

Tonsillectomies

In the United Kingdom, tonsillectomy is the commonest form of surgery in children under 5 years of age, and nearly a third of all children admitted to hospitals for surgery under the age of 15 are admitted for this operation. About 200,000 tonsillectomies are performed annually at a cost to the health service of $3 million.[6]

A Health Ministry memorandum of March 1966 urged hospital authorities to abolish rules restricting visiting by parents, particularly those forbidding visits on the day of the tonsillectomy. In the past, parents accepted the reasons given for their exclusion—the danger of raising the child's blood pressure, of causing hemorrhage from emotional strain, and of subjecting the child to infection—all dangers increased by a mother's presence, the hospitals said.

The Platt Committee found no grounds for these claims—nor do many hospitals, including the London teaching hospitals. On what, the association wonders, do the other hospitals really base their reason for excluding mothers?

In writing to the Minister of Health, the association has expressed concern over the number of tonsillectomies performed on small children in hospitals restricting visits, particularly as indications of the immediate necessity for many operations are not always evident. Whether tonsils are removed or not depends sometimes on the facilities available and the judgment of the physicians concerned. Regional variations are large. A Ministry of Education survey for 1958 found that in one county, Buckinghamshire, 34.8 percent of all 14-year-old children had had their tonsils removed, but in another, neighboring Bedfordshire, the proportion was only 9.2 percent, although the counties are much alike in climate and economic conditions.[7] The association has strong-

ly urged the Minister of Health to initiate research into the reasons for differences such as this.

In 1967, the association conducted a survey of children in long-stay hospitals, a subject barely dealt with by the Platt Report but one likely to become very important in the future as the number of handicapped children who survive into adulthood increases. In the same year, the chairman of the association spoke to the Royal College of Nursing on the subject of the child patient, and delegates were sent to a conference arranged by the Hospital Centre in London (a clearinghouse for information about hospitals) and the British Pediatric Association on the planning of new units for children. This year, the association plans to survey children in outpatient and casualty departments and the conditions under which they are nursed in adult wards.

Activities and aims

Local NAWCH groups continue to inform parents of the need to visit and stay with their children when facilities are available and to press for them when they are not. Local groups provide transportation for the mother and créches to care for other children in the family to make it easier for the mother to visit or stay in the hospital with the sick child. The association also runs a central hospital information service to answer questions about local hospital conditions. Published material and personal help are available on the subject of preparing a child for a hospital stay.

Both the NAWCH and the American Association for Child Care in Hospitals (AACCH) have similar general aims. NAWCH seeks to promote the welfare of sick children in general and to bring to the notice of the public, and especially parents, teachers and all concerned in the public health services, the special need of children in hospitals. AACCH is an association working to make a child's hospital experience constructive and strengthening for the present and future well-being of both the child and his family.

The historical backgrounds and composition of the two associations, of course, differ. In the United States, the move to liberalize the handling of children in hospitals has come directly and overtly from members of the hospital professions themselves. AACCH is essentially a professional organization. Its members include pediatricians, nurses, social workers, child-care workers, and members of allied professions. Although professional qualifications are necessary for *full* membership, parents may become *associate* members. (Inquiries about AACCH should be made to Mrs. Barbara S. Haas, Child Life Department, Johns Hopkins University Hospital, Baltimore, Md. 21205.)

NAWCH aims at bridging the gap between lay and professional people. It has emerged as the organized community wing of a struggle that goes on simultaneously in both groups, though more individually in professional fields, for education in and reform of pediatric practice. NAWCH is the articulate propaganda wing of a movement that, with the help of its professional members, digests research findings in child development and presses for putting them into effect. Through its work and wide newspaper and television coverage, the emotional needs of healthy as well as sick children are more widely recognized.

My impression from the Philadelphia conference and from visiting seven American hospitals afterward has led me to believe that the meaningful occupation of children by constructive play and education is more generally developed in American hospitals than in British. Programs in American hospitals impressed me as being more nearly comprehensive and universal than any I have seen in the United Kingdom.

The larger London and provincial hospitals have good play and education programs, but these seem to be individual efforts that have not yet impinged on the consciousness of the directors of hundreds of other children's wards. Resources for such programs are very limited: the Save the Children Fund provides about 16 well-trained play leaders for various hospitals, a few hospitals appoint and pay the salaries of their own play nurses, and others make do with volunteer play ladies. The hospital schoolteacher service, which many do provide, tends to concentrate on the educational needs of the long-stay patient.

It seems to me that U.K. hospital staff members and teachers should continue to study at first hand child-life programs in U.S. hospitals. Because interchange of ideas on and experience with caring for sick children are so important to the well-being of the child, I hope that money and initiative will be forthcoming in both associations to allow exchanges of representatives.

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[1] Ministry of Health: The welfare of children in hospital. Her Majesty's Stationery Office, London, England. 1959.

[2] Robertson, J.: Young children in hospital. Tavistock Publications, London, England. 1958.

[3] Address given by the Chairman of the Mother Care for Children in Hospital, at its first annual general meeting, London, England. 1963.

[4] Robinson, Kenneth: Address given at the Fourth Annual Conference of the National Association for the Welfare of Children in Hospital, London, England. 1966.

[5] Ministry of Health: On the state of public health. (Annual Report of the Chief Medical Officer of the Ministry of Health for the year 1966.) Her Majesty's Stationery Office, London, England. 1966.

[6] Consumer Association: *Drug and Therapeutics Bulletin*, November 1966.

[7] Ministry of Education: Health of the school child. Her Majesty's Stationery Office, London, England. 1958.

The family is the little child's cosmos; for him everything beyond home is outer space.

Dorothy V. Whipple, M.D.*, "Dynamics of Development: Euthenic Pediatrics," *McGraw-Hill Book Co., New York, 1966.

HERE and THERE

For youth

A nationwide campaign to provide constructive opportunities to young people next summer was launched in Washington, D.C., January 29–31, at a Youth Opportunity Conference called by Vice President Humphrey as chairman of the President's Council on Youth Opportunity. The 600 persons who attended included the mayors, the youth coordinators on their staffs, and representatives of young people from the Nation's largest cities, as well as representatives of the Urban Coalition and other voluntary organizations.

As a result of experience last year (see column 2), the conferees urged that greater provision be made this year for advance planning, coordination of activities, and continuity between summer programs and year-round opportunities for young people. The Council provided stimulus for following through on these recommendations by making $1½ million available for grants to 50 of the largest cities to add staff members to the mayors' offices for year-round coordination and planning of programs for young people. By mid-March, all 50 cities had received planning grants ranging between $20,000 and $60,000. In making the grants, the Council urged the cities to use all possible resources to enhance young people's opportunities for education, employment, recreation, camping, and health.

The Council has also developed the following program aids: "A Guide for Voluntary Organizations (VO), Information Report No. 101"; "Developing Youth Opportunity Programs"; and a bibliography of material from Federal agencies relating to summer programs for disadvantaged young people. (Available without charge from the President's Council on Youth Opportunity, 801 19th Street NW., Washington, D.C. 20506.)

On March 5, President Johnson announced the appointment of a 14-member Citizens Advisory Board on Youth Opportunity to work with the Council and to advise him on—

1. Ways of enhancing the opportunities of disadvantaged young people to prepare for adult responsibility.
2. Coordination of Federal activities pertaining to young people's needs.
3. Local, State, and private action to extend opportunities for young people.
4. Evaluation of the Council's progress and ways to accelerate the Council's progress.

William O. Beach, county judge, Montgomery County, Tenn., is the board's chairman.

The President has also appointed a new group called the National Alliance of Businessmen, composed of industrial leaders. The group is working to develop summer jobs in industry for approximately 200,000 disadvantaged young people.

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Apathy not anger toward the conditions of their lives marked many of the young people who took part in the summer of 1967 in programs of work, recreation, and education offered with Federal support to young people living in city slums. The Trans-Century Corporation, an independent research agency in Washington, D.C., reached this conclusion from a 5-month study made last summer and early fall of summer programs offered in 11 cities through grants from the U.S. Departments of Labor and Health, Education, and Welfare—East St. Louis, Chicago, Washington, D.C., Jersey City, New York City, Atlanta, Houston, Oakland, Los Angeles, Omaha, and Cleveland.

The agency found, on the one hand, that the young people who were angry were *very* angry and highly dissatisfied with the program but that they were in the minority; and, on the other, that the majority were apathetic about slum conditions and were satisfied with the program, particularly for material reasons—access to swimming pools and money in the pocket—or because the alternatives to taking part were doing nothing, watching TV, or babysitting.

In a report made to the Department of Health, Education, and Welfare last December, the agency was critical of the program as a whole. It found that many local programs seemed designed to keep young people off the street and from committing violent acts, not to help them improve the conditions of their lives; that many jobs were made-work of no lasting value; that education programs often did not tie in with regular schoolwork or with vocational needs.

Pointing out that the need for a summer program for young people will be even greater this year than last, the agency recommended that action be taken to raise the objectives of the program, improve its organization and administration, develop national guidelines for local programs, and allocate funds in time to allow for good planning. It also recommended that the jobs provided young people be meaningful and that efforts be made to reach out to help the hard-to-reach young person—the boy who is never home and the girl who is always home because she is caring for younger brothers and sisters—and to involve the young people themselves in planning and operating the programs.

The agency based its findings on information gathered by a team of interviewers who went to selected areas in the 11 cities and talked with nearly 6,000 boys and girls who were involved in the program last summer.

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In an effort to give young people a voice in decisions affecting community life, the board of supervisors for Santa Cruz County (Calif.) recently appointed a 17-year-old boy to the Santa Cruz County Planning Commission. To find the right young person, the board consulted a high school principal, the presi-

dent of Cabillo Community College, a civic leader, and the head of a high school student council. The qualifications the board sought were an interest in government, mature judgment, and ability to work with adults.

The young person selected, Tom Noble, is a member of his school's student council, has a part-time job, and is reportedly a good student. His appointment, according to a former chairman of the Governor's Advisory Commission on Children and Youth, has had an "electric effect" on young people's groups in the county, which now seem to be "taking themselves more seriously."

Child welfare

About 607,900 children and young people under 21 years of age were receiving child welfare services from State and local departments of welfare on March 31, 1967, an increase of 7.1 percent over the number receiving services on the same date in 1966, according to figures reported to the Children's Bureau. However, the distribution of such children by living arrangement was the same for both years: 48 percent were living in their own homes, with relatives, or independently; 34 percent, in foster family homes; 10 percent, in institutions; 7 percent, in adoptive homes; and 1 percent, under some other living arrangement.

In 1967, the Bureau for the first time gathered information on the number of children receiving foster care purchased by State or local public welfare departments from voluntary agencies and institutions. As of March 31, 1967, approximately 52,100 children were in foster care under such purchase-of-care arrangements—19 percent of all children receiving child welfare services from public agencies who are in foster care. Of these 52,100 children, 28,900 (55 percent) were in institutions; 22,800 (44 percent), in foster family homes; and 400 (1 percent) in group homes. Of those for whom institutional care was purchased—47 percent of all children served by public welfare agencies who were in institutions—22,400 were in child welfare institutions for neglected, dependent, and emotionally disturbed children; 1,300, in maternity homes; and 5,200, in other types of institutions.

The Bureau also gathered information for the first time for 1967 on the number of licensed foster family homes and group homes for children and the auspices under which they operated. According to the reports, as of March 31, 1967, there were 132,700 licensed foster family homes in the United States, 73 percent of which were under the auspices of public agencies; 22 percent, of voluntary nonprofit agencies; and 3 percent were independent (for 2 percent the auspices were not reported). There were also about 700 licensed group homes, 58 percent of which were under the auspices of public agencies; 35 percent, of voluntary nonprofit agencies; and 7 percent were independent.

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In an effort to increase public acceptance of day care for children as a necessary community resource, the Canadian Welfare Council last March began an 18-month study of day-care centers in 102 cities in Canada, with a grant from the Canadian Department of National Health and Welfare.

In carrying out the study, the Council will—

- Examine the organization, policy, operation, programs, and physical facilities and equipment of day-care centers in the areas studied and the extent to which they are accepted by the communities.
- Obtain information on the number of persons on the staffs of the day-care centers and their duties, educational qualifications, experience, and wages.
- Obtain information on the numbers, age, sex, and economic status of the parents who use the day-care services.
- Determine the capacities of present facilities and the extent to which they are being used and identify unmet needs.
- Analyze the status of day-care legislation in Canada.

Reports of the study's findings will be published at regular intervals during the 18 months.

Mental retardation

Mentally retarded children can now become physical fitness CHAMPs and belong to a special club through a program that parallels the President's physical fitness program for children and young people. Begun in February by the Joseph P. Kennedy, Jr. Foundation and the American Association for Health, Physical Education, and Recreation (AAHPER) in cooperation with the President's Council on Physical Fitness, the program offers a CHAMP emblem and membership in a 30-Hour Club to mentally retarded children and young persons (ages 8 to 18) who meet certain standards.

To get these awards, a child or young person must complete a seven-part physical fitness test suitable to his age offered through schools, institutions, and recreation associations and 30 hours of athletic and recreational activities performed outside of school within 3 months. AAHPER also offers gold and silver emblems to children who complete less than the seven activities, auxiliary bar patches for those who repeat their success, and a progress certificate for the physically limited child.

Maternal and child health

Intrauterine devices (IUD's) are effective as contraceptives though not so effective as hormonal contraceptives, according to the Advisory Committee on Obstetrics and Gynecology, Food and Drug Administration, U.S. Department of Health, Education, and Welfare. The committee warns, however, that the use of IUD's carries a small but definite risk of infection and uterine perforation.

To cut down the risks, the committee has suggested legislation to bring IUD's under Federal regulation. The regulations would require that IUD's and disposable "introducers" be packaged as a unit and sterilized; that instructions for use, precautions, and contraindications be included in labeling for physicians; and that a method be provided for physicians to report adverse reactions confidentially.

The committee's recommendations are based on information obtained from FDA's files, worldwide medical literature, manufacturers, and members of the American College of Obstetricians and Gynecologists. They are contained in a document, "Report on Intrauterine Contraceptive Devices," available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (Price: 55 cents.)

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Restricted or poor diets were the exception during pregnancy among a group of 318 young women from depressed areas of New York City, a research team from the School of Public Health, University of North Carolina, recently

found in a study of the nutritional resources and dietary practices of 196 Negro women and 122 Puerto Rican women conducted shortly after they were delivered of babies at three city hospitals. Nearly two-thirds of the women reported that they saw the need for special diets during pregnancy. About half the Negro women and a quarter of the Puerto Rican women had modified their diets considerably on instructions from physicians, nurses, or nutritionists. The Puerto Rican women had continued on their traditional diets but they had started prenatal care earlier than the Negro women. Nearly all of the women in both groups had eaten a wide variety of meats, vegetables, and fruits.

Although the women had lived under crowded conditions, nearly all of them reported having had access to stoves, sinks, and refrigerators. They had eaten at home and cooked for themselves or shared cooking duties with others. However, about 6 out of 10 had either shared responsibility for marketing or did no marketing during the last 2 months of pregnancy.

The study was conducted with a grant from the Children's Bureau.

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The U.S. Public Health Service (PHS) recently issued the first license to manufacture and distribute a live attentuated mumps virus vaccine after an 18-month study of the vaccine for safety and potency by the National Institutes of Health's Division of Biologics Standards. The license was issued to Merck, Sharp and Dohme, the drug company that developed the vaccine.

The new, single injection vaccine, prepared from virus grown in chick embryo culture, is intended primarily for children approaching puberty, adolescents, and adults (especially males) if they have not had mumps, and it is considered beneficial to susceptible persons living in institutions where epidemics spread easily. PHS does not recommend it for pregnant women or in routine use for infants and young children until more information on the duration of immunity is available, and warns against its use for persons allergic to eggs and neomycin.

According to PHS, about 80 percent of all people in the United States have mumps before adulthood. The disease is usually innocuous in childhood, although it sometimes causes complications. However, it may affect the testes and ovaries adversely if contracted after puberty.

In nationwide clinical tests carried out by the manufacturer, about 95 percent of the 6,500 susceptible children and adults to whom the vaccine was administered developed protective antibodies.

Infant mortality

The provisional rate for 1967 and the final rate for 1966 indicate that the declining trend in infant mortality in the United States is accelerating, according to a Children's Bureau analysis of figures from the National Center for Health Statistics. The provisional rate for 1967—22.1 infant deaths per thousand live births—represents a 6.8-percent drop from the final rate for 1966. The 1966 rate—23.7 infant deaths per thousand live births—represents a 4-percent drop from the 1965 rate of 24.7. During the 10 years before 1965, the infant mortality rate had declined by less than 0.8 percent a year.

Infant mortality rates for the States in 1966 ranged from a low of 18.1 for Nebraska to a high of 38.8 for Mississippi. Mississippi's rate in 1966, however, represents a 4.4 percent drop from its 1965 rate of 40.6.

Equally great variations in infant mortality rates existed among the more than 3,000 counties in the United States during the period 1961–65. Ten percent had rates of 17.8 per thousand live births or lower, but 10 percent had rates over 38.7. Slightly over 1 percent—42 counties—had 400 or more infant deaths beyond the number that would have given them an infant mortality rate of 17.8.

Education

The new National School Policies for Title VI of the Civil Rights Act of 1964 issued in March by the Department of Health, Education, and Welfare (HEW) for the first time set a date for the end of segregation in public schools receiving Federal money: by the beginning of school year 1968–69 or 1969–70. In issuing the new policies, HEW pointed out that they are based on the provisions of Title VI of the act, HEW regulations for Title VI, and Federal Court decisions relating to Title VI.

The new policies supplant and replace earlier statements, though they carry over many basic points. Earlier policies usually applied to the ending of dual school systems, mostly in Southern and Border States. The new policies emphasize ending practices that deny equal educational opportunities to children because of race, color, or national origin. They require the end of such practices as assigning the poorest teachers and giving inferior equipment to schools attended largely by children from minority groups. They also hold local school districts responsible for building new schools or for adding to or renovating old ones in ways that do not segregate children and for hiring and assigning teachers and other professional staff members without regard to race.

Staff members of HEW's Washington and regional offices are available to provide State and local school officials with advice and assistance in solving problems related to Title VI. In addition, the Department's Office of Education is authorized by Title IV to help local school authorities prepare and put desegregation plans into effect and to meet special problems.

Juvenile delinquency

Concern about the misuse of juvenile detention facilities by the police and the courts came out strongly at a national conference on juvenile detention held in Grafton, Ill., on March 11–15. The first of its kind, the conference was sponsored by the Southern Illinois University under a grant from the Office of Juvenile Delinquency and Youth Development, in cooperation with the Children's Bureau. The 51 persons from 27 States and the District of Columbia who attended included the superintendents and other staff members of 35 detention homes and consultants on detention from Federal and State agencies.

Many of the superintendents testified to overcrowded conditions in the facilities they operated, but said that the overcrowding was largely due to the detention of children who did not need it. In answering a questionnaire circulated at the conference, 24 of the 35 superintendents reported that their facilities had been overcrowded at some time during the past year; eight, that they had been overcrowded all the time; and eight, over 50 percent of the time. Some of the superintendents reported a falling off in overcrowding after the Supreme

Court of the United States rendered its decision in the Gault case (see pages 86 and 90), but that this was temporary.

Papers presented were on the following subjects: the function of detention, programing in a detention facility, State responsibility for detention, the implications for detention of trends in juvenile court law, and drug abuse among juveniles and the care of drug users in detention.

Although it was not in the agenda of the conference, the detention superintendents in attendance formed a new organization for staff members of detention facilities to be known as the National Juvenile Detention Association.

A full report of the conference will be made available by the Southern Illinois University in the future.

Health message

On March 4, 1968, President Johnson set forth five major health goals for the Nation in a message to Congress on Health in America. They were—

1. To reduce sharply the infant mortality rate.
2. To meet the need for more physicians, nurses, and other health workers.
3. To deal with the rising costs of medical care and to ensure the most efficient use of health resources.
4. To lower the toll of deaths caused by accidents.
5. To launch a nationwide "volunteer effort" to improve the health of all Americans.

In line with these goals the President proposed that Congress provide for—

- *Expansion of maternal and child health programs* through a Child Health Act of 1968 to assure that all needy mothers receive adequate prenatal and postnatal care; a safe delivery by trained health professionals; competent examination of the child at birth and expert treatment when needed; the best of modern medical care for the infant during his first year to prevent disease, cure illness, and correct handicaps; an opportunity for family planning on a voluntary basis.
- *Expansion of child health services* under Medicaid; the federally aided projects for the comprehensive health care of children and youth; project Head Start; Federal-State crippled children's services; and the Neighborhood Health Centers supported by the Office of Economic Opportunity.
- *The establishment of a Center for Population Studies and Human Reproduction* in the National Institute of Child Health and Human Development.
- *Expansion of family planning programs* to make such services accessible to women who want them.
- *The extension of health manpower programs* for training professional and auxiliary workers in the health field through a Health Manpower Act of 1968 to continue and strengthen the Health Education Act of 1963, the Nurse Training Act of 1964, the Health Personnel Training Act of 1966, the Health Research Act of 1965, and the Graduate Health Training Act of 1964.
- *Modernization of the health personnel system* of the Department of Health, Education, and Welfare through a Health Personnel Act of 1968 to provide for pay increases to attract and retain high caliber professional persons and a new promotional system based on quality of performance.

The President also asked Congress to authorize the Secretary of Health, Education, and Welfare to—

- *Employ new methods of payment for medical care* under Federal health programs to effect the provision of high quality care at lower cost.
- *Establish a reasonable cost range for drugs* provided under Federal health programs.
- *Prepare a United States Compendium of Drugs* in cooperation with pharmaceutical manufacturers, physicians, and pharmacists.

The President announced that he had directed the Secretary of Health, Education, and Welfare—

- To devise a plan of organization to achieve the "most efficient and economical operation of the health programs of the Federal Government."
- To begin extensive tests of incentives to reduce the cost of medical care.
- To devise, in cooperation with the Secretaries of Transportation and Defense, a test program to help States and communities develop effective emergency rescue systems.
- To furnish administrative services to a new President's Council on Physical Fitness and Sports, to be composed of Cabinet members under the chairmanship of the Vice President.

The President also called on State and local governments and private enterprise to step up their efforts to bring better health to the American people. He especially mentioned the medical and hospital associations, the health care institutions, the health insurance industry, the communication media, voluntary civic associations, employers and labor unions, charities, and church groups.

Unmarried mothers

Casework service is the most frequent type of service provided unmarried mothers served by 122 maternity homes and family and children's agencies affiliated with the Florence Crittenton Association of America, the National Conference of Catholic Charities, and The Salvation Army, according to the findings of a survey sponsored by these agencies, with support from the Children's Bureau. The survey obtained data by a computerized reporting system on more than 21,000 unmarried mothers and the services provided them by the reporting agencies in 1966.

In regard to services it found that—

- Though casework service was given to 86 percent of the mothers, it was a need unmet for 4 percent of the white mothers and 7 percent of the nonwhite mothers.
- Adoption counseling was provided for 82 percent of the mothers—to 85 percent of the white mothers but only 60 percent of the nonwhite mothers.
- 72 percent of the mothers received maternity home care, but only 56 percent of the nonwhite mothers received such care as compared with 75 percent of the white mothers. About 5 percent of all received some other type of residential care.
- Accredited education courses were provided for about half the mothers under 15 years old, for over 43 percent of those between 15 and 17, and for 9 percent of those between 18 and 21.

Among the findings about the unmarried mothers themselves were the following:

- The majority of the mothers (88 percent) were white.
- The nonwhite mothers were on the whole younger than the white mothers: 47 percent were under 18 as compared with only 24 percent of the white mothers.
- Almost half the unmarried mothers (48 percent) were students at the time they became pregnant. A third of the students were in college.
- Almost half (47 percent) were em-

ployed, mostly as office workers, sales clerks, or service workers.

• About 70 percent were living with one or both parents at the time of conception. About a third (32 percent) were from broken homes.

• The majority (70 percent) planned to place their babies for adoption.

The survey found that the reputed fathers were, for the most part, in the same age brackets as the mothers. Over half were students; 17 percent were unskilled laborers; and 12 percent were in military service. Seven out of 10 were single.

The survey also found that while the agencies had interviewed one or both parents of the unmarried mother in 59 percent of all cases and in 72 percent of the cases in which the unmarried mother had been living at home when she became pregnant, interviews with the father of the child were held in only 7 percent of the cases.

. . .

Although the rate of births out of wedlock (number of births per thousand unmarried women aged 15 through 44) nearly trebled between 1940 and 1957, it tended to level off between 1958 and 1965, according to figures gathered by the National Center for Health Statistics, U.S. Public Health Service. From a study of birth certificates in 34 States and the District of Columbia, the center found that the rate rose from 7.1 in 1940 to 21.0 in 1957, but between 1958 and 1965 increased some years and decreased others. In 1965 it was 23.5.

Over the years, the difference between rates for nonwhite and white women has declined. In 1950, the rate of reported births out of wedlock among nonwhite women was 12 times as high as among white women but in 1965 it was only 8 times as high. While the rate among nonwhite women declined 1 percent between 1960 and 1965, the rate among white women rose 26 percent. The rate among nonwhite teenage girls (15 to 19) declined 5.6 per thousand between 1957 and 1965, while among white teenage girls the rate increased by 1.5 births per thousand. In both groups, the rates of births out of wedlock were higher in 1965 and had increased more since 1940 among women over 25 than among teenage girls.

These and other facts are contained in "Trends in Illegitimacy: United States, 1940–1965," Series 21, No. 15, National Center for Health Statistics. (Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price: 55 cents.)

BOOK NOTES

VENTURES IN JUDICIAL EDUCATION. The National Council of Juvenile Court Judges. Allen-Fisher Press, Chicago, Ill. 1967. 168 pp. Mailing charge only.

Addressed to persons interested in the problems of children's courts or in continuing education for professional persons, this book describes a 3-year demonstration training program for juvenile court judges. The program was conducted by the National Council of Juvenile Court Judges in collaboration with National Training Laboratories and the George Washington University Center for the Behavioral Sciences.

The book begins with a description of a pilot institute held in 1961 and attended by 27 judges from 17 States, which became a base for the development of a program of five national 6-day institutes and five 2-day State meetings held each year for the 3 years of the demonstration. It goes on to describe the training methods and materials used in the institutes, the procedures for continuing evaluation, and the results of studies on juvenile court judges and their practices undertaken to provide baseline material for the institutes.

The book maintains that one major result of the program has been the strengthening of the National Council's ability to carry on educational activities and to conduct research on subjects of judicial concern. It also maintains that the program was chiefly responsible for stimulating the formation of new State councils of juvenile court judges for the same purpose.

ATLAS FOR SOMATOTYPING CHILDREN. G. Petersen, M.D. Charles C Thomas, Springfield, Ill. 1967. 244 pp. $63.

The outcome of 8 years' research on the constitution of children is reflected in this atlas for somatotyping children, the author says in his preface. He has prepared the atlas because in his opinion "knowledge of physique is of vital importance in the medical care of children" and somatotyping of children can be useful in detecting "basic differences in human function and behavior" and in pointing out "physiological and behavioral peculiarities."

The book is accompanied by a chart—"Scheme of Somatotypes in Children"—illustrated, as is the book itself, with photographs selected from 12,000 taken of schoolchildren in the Netherlands.

PATTERNS OF SOCIAL FUNCTIONING IN FAMILIES WITH MARITAL AND PARENT-CHILD PROBLEMS. Gerson David. University of Toronto Press, Toronto 5, Ontario, Canada. 1967. 297 pp. $7.50.

The Family Diagnosis Research Project on which this book reports was carried out by the Family Service Association of Metropolitan Toronto, a casework agency for families with marital or child-parent problems, on a sample of 123 families. The project tried to measure the "role perception and role function" of the family members. It used a model developed by the Allegheny General Hospital of Pittsburgh—a questionnaire answered by family members—and the evaluations of family caseworkers.

The project found that the main problems in middle class families centered on household tasks and child rearing; in lower class families, on affection (sex and communication). But lower class families were more "egali-

tarian" as far as the division of household labor went. The social workers thought that they were better able to help upper and middle class families than lower class families. The author points out that this may have been because lower class families must spend so much of their energy to just keep going that they often have very little left to cope with their other problems.

The model provided "an objective tool which yields scores or classifications independently of who does the scoring," the author concludes.

THE PREDICAMENT OF THE FAMILY. Edited by Peter Lomas. International Universities Press, New York. 1967. 219 pp. $5.50.

The nine papers presented in this book, the third volume of the International Psycho-Analytical Library on the family, illustrate the work of several British psychoanalysts. Centering on the family as a unit of study, the contributors discuss the effects on personality of marriage, childbirth, the mother and the baby as a unit, psychotherapy in adolescence, family structure, and family therapy.

In the first paper, the editor sets the tone by discussing the meaning of help for the individual patient in psychoanalysis through help for the family. He says: "It is always comforting . . . to obtain confirmation of the patient's perceptions from others in the family, and this can be done if more than one member is analysed."

PARENTS LEARN THROUGH DISCUSSION: principles and practices of parent group education. Aline B. Auerbach. John Wiley & Sons, New York. 1968. 358 pp. $7.95.

That parents can be helped to become better parents through group education is a major theme of this book written by a specialist in parent education long associated with the Child Study Association of America. Parent group education, she maintains, brings educational experience to parents that adds to their understanding of their children; causes them to question old ways of thinking, feeling, and acting; and helps them develop new methods, as needed, of dealing with their children, themselves, and their environment.

The author takes up the following aspects of parent group education: principles; practices; group interaction; the role of the leader; training for leadership; the difference in method and goal of group education, group dynamics, and group counseling; and needed research. She also discusses ways of working with groups of parents with special problems: expectant parents, unmarried mothers, parents of handicapped or disturbed children, adoptive and foster parents, and parents of low socioeconomic status.

British publications

SCHOOLS FOR YOUNG OFFENDERS. Gordon Rose. Tavistock Publications, London, England. 1967. 244 pp. $9.50. U.S. Distributor: Barnes & Noble, Inc., 105 Fifth Avenue, New York, N.Y. 10003.

Describes the development, structure, and operations of schools for the education and training of juvenile offenders in England and Wales and identifies and examines some of the problems involved in their operation.

FAMILY ADVICE SERVICES: an exploratory study of a sample of such services organised by Children's Departments in England. Aryeh Leissner. Longmans, Green & Co., London, England, in association with the National Bureau for Co-operation in Child Care. 1967. 86 pp. $2.25. U.S. Distributor: Humanities Press, 303 Park Avenue South, New York, N.Y. 10010.

Reports on the findings of a study of family advice services established in the children's departments of local governments in England with support from the Home Office.

SERVICES FOR HANDICAPPED YOUTH IN ENGLAND AND WALES. Wallace W. Taylor and Isabelle Wagner Taylor. International Society for Rehabilitation of the Disabled, 219 East 44th Street, New York, N.Y. 10017. 1966. 340 pp. Single copies free from the Society.

Reports on a study of governmental and voluntary services available to handicapped children ages 14 through 21 in England and Wales, including educational; vocational assessment, guidance, and placement; vocational training; employment; medical; and welfare.

INVESTMENT IN CHILDREN: a symposium of positive child care and constructive education. Edited by M. L. Kellmer Pringle. Longmans, Green & Co., London, England. 1967. 180 pp. $2.25. U.S. Distributor: Humanities Press, 303 Park Avenue South, New York, N.Y. 10010.

Includes 10 papers concerning the roles of education, pediatrics, psychiatry, and social work in theory, policy, administration, and practice in preventing mental and physical handicaps in children and in helping them develop to their full potential. The papers were originally presented at the 1965 conference of the National Bureau for Co-operation in Child Care, London, England.

THE YOUNG OFFENDER. D. J. West. International Universities Press, 239 Park Avenue South, New York, N.Y. 10003. 1967. 333 pp. $6.50.

A British psychiatrist discusses the nature and extent of crime among young people, the backgrounds of the offenders, psychological theories of delinquency, sex offenses, drug use, and violence, and penal systems, and warns of the dangers of drawing parallels between countries and of generalizing from statistics.

IN THE JOURNALS

Growing up in Appalachia

What it is like to grow up in Appalachia is described by two psychiatrists, Robert Coles, M.D., and Joseph Brenner, M.D., in an article in the January 1968 issue of the quarterly, *American Journal of Orthopsychiatry.* ("American Youth in a Social Struggle (II): the Appalachian Volunteers.") The article reports on the psychosocial factors confronting the college students who went to work as volunteers in Appalachian mountain communities in the summers of 1965 and 1966.

The authors contrast the child-rearing practices of the mountain people with those of other rural white Southerners, of migrants, of urban Negroes, and of suburban white people. Appalachian mothers, they found, seem close to their children and yet detached from them. They hold their babies with "obvious warmth" and "breast feed them with pleasure," but they do not give the same kind of continuous attention to their children's movements and noises as do anxious suburban mothers. They anxiously train their children very early to use outhouses, but seem undisturbed by destructive play in the home.

While Appalachian children are given a great deal of bodily freedom, the authors report, they have little privacy from other members of the family—brothers and sisters, aunts, uncles, cousins, grandparents, as well as parents—and this seems to make for greater closeness among siblings and for less of the intense parent-child relationships seen in suburban nuclear families. Work comes early in the form of family tasks.

Identity crises and rebellion, the authors say, are not so common among young people in Appalachia as elsewhere because of their strong sense of family and community. Because of the scarcity of jobs, many young mountain people leave home, but they leave reluctantly.

The college volunteers who came to the area to build roads, teach the three R's, and help to effect better sanitation were, as one Appalachian youth put it, "mighty strange hereabouts," but according to the authors, they and their mountain hosts learned to come to terms with each others' customs and tempo as they worked together to alleviate some of the difficulties of the region.

Parents of fatally ill children

A study of social work with the parents of 165 fatally ill children found that those who had ego strength and who from the start showed ability to cope with the stress of their children's illness were those most likely to decide what social work they needed and to use what they got most effectively, report Priscilla A. Lang and Jeanette R. Oppenheimer in the March 1968 issue of *Social Casework.* ("The Influence of Social Work When Parents Are Faced With the Fatal Illness of a Child.") The parents whose adaptability was poor often had to be helped to see the need for and to use social work. And the caseworker was able to predict from the first interviews which parents would have the greatest need for social work. The study was conducted between 1961 and 1964 at the Roswell Park Memorial Institute, Buffalo, N.Y.

According to the authors, after the first interviews the social worker rated 52 couples as likely to be "successful" in coping with the situation; 88 as likely to be "moderately successful"; and 25 as likely to be "unsuccessful." While their children were in treatment, the parents were offered psychological support, help in obtaining care for the child, and help in developing ability to cope with the situation. Of those expected to be "successful" or "moderately successful" who sought casework, 92 used an average of 26.7 casework interviews each; 12 of the "unsuccessful" couples required an average of 69.8 interviews each. Only a few of the "successful" couples used all three services; 11 required no help at all.

At the end of the casework, the authors report, most of the parents were still in the same classifications.

Campus preschool projects

"Mary is beginning to use longer and more descriptive phrases, to become more aware of her environment, and to interrelate with other people." This comment from a student volunteer reveals the aims of the West Berkeley Preschool Project at the University of California at Berkeley described by Norma H. Stauffer in the February 1968 issue of *The YWCA Magazine.* ("A Warm One-To-One Relationship.") Under the 3-year-old project, sponsored by the College and University Division, National Board, YWCA, each academic year 65 students commit themselves to giving a minimum of 2 hours a week to develop a warm one-to-one relationship with a culturally deprived preschool child and thus to help the child become more receptive to learning and to relationships with other people.

According to the author, the volunteers are chosen on the basis of emotional maturity, experience with and interest in young children, knowledge of the community, wide interest range, and positive attitudes toward minority groups. The children are referred by school principals, Headstart and nursery school teachers, social workers, parents of participants, and others. The activities the volunteer plans for the child depend on his assessment of the child's needs. These have included trips to the park, the zoo, the library, department stores, construction sites, airports, yacht harbors, and campuses; painting; clay modeling; making cookies; and planting seeds.

Comments of children, parents, and volunteers indicate that on the whole participation in the program has been satisfying, the author reports.

Disturbed adopted children

Psychiatric disturbances in adopted children may be related to unconscious, unresolved aversion to parenthood in the adoptive parents, write Shirley A. Reece and Barbara Levin in the January 1968 issue of *Social Work* ("Psy-

chiatric Disturbances in Adopted Children: A Descriptive Study"). If this assumption is correct, the two maintain, adoption workers must be helped to find quicker ways of spotting personal problems in prospective adoptive parents that could keep them from becoming successful parents.

The authors base their assumption on the results of a study of 30 cases involving adopted children ranging in age from under 2 years to nearly 18 out of a total of 1,017 cases of disturbed children handled by a psychiatric clinic in San Francisco between 1954 and 1963. None of the children had been adopted by relatives.

The adoptive parents complained of aggressive and antisocial behavior in the children at home and at school. Sixteen couples had asked for or were considering asking for their children to be placed away from home, and four were trying to revoke the adoption. In the course of the agency's work, the parents' motives for adopting came into question: they had apparently adopted children as a means of resolving personal and interpersonal problems. They appeared defensive, rigid, and secretive; they denied problems existed or projected blame on others.

The authors report that a study is underway of children referred to the agency who are living with their own parents to compare their cases with those of the adopted children in this study.

Children from broken homes

Children whose fathers had been absent from home for 2 or more years saw the duties of parents in about the same light as children from intact families, Mary Margaret Thomes says in reporting on a study she had made concerning the effects of paternal absence on children in the February 1968 issue of the *Journal of Marriage and the Family*. ("Children with Absent Fathers.") Her subjects were 47 children whose parents were divorced or separated and 37 children from intact families, whom she questioned individually at home concerning their ideas about parental duties, the makeup of the family, their relations with other children, and themselves. Their ages ranged from 9 to 11 years. The parents were matched by age, education, and economic status (low), and all were white.

Though both groups of children chose "father" less often than "mother" as the person to perform such parental duties as discipline, only four children from broken homes failed to include "father" in their description of a "home," the author found. About a third in both groups said they would go to their fathers first with a problem. Hostility toward a father was about as great in both groups. When asked what they wanted most for the family, only six children from the broken homes said a "father." Children in both groups scored alike in describing themselves and what they would like to be.

The author suggests two reasons why the absence of the father had had so little effect on the children: their age and the length of time the fathers had been gone. From 9 to 11, she maintains, is a period of "relative quiescence in personality development," and, as the absent fathers had been away from home for at least 2 years, the immediate period of adjustment following the father's departure was past.

guides and reports

TEACHING THE DISADVANTAGED. Gertrude Noar. Department of Classroom Teachers, National Education Association, 1201 16th Street NW., Washington, D.C. 20036. "What Research Says to the Teacher" series no. 33, 1967. 33 pp. 25 cents.

Discusses the specific learning problems of disadvantaged children and suggests teaching methods to help overcome them.

ROADS TO MATURITY: proceedings of the Second Canadian Conference on Children, Montreal, Canada, October 31–November 4, 1965. Edited by Margery King. University of Toronto Press, Toronto 5, Ontario, Canada. 1967. 146 pp. $5.95.

Contains the formal papers and discussion group reports of a conference centered on problems impeding the development of children and young people in Canada and on new methods of dealing with them.

LET'S TRY IT: conserving our natural resources. Girl Scouts of the United States of America, 830 Third Avenue, New York, N.Y. 10022. 1967. 25 pp. 35 cents.

Presents a revision of a manual for young people on why and how to conserve the Nation's natural resources.

MILD MENTAL RETARDATION: a growing challenge to the physician. Formulated by the Committee on Mental Retardation, Group for the Advancement of Psychiatry, 104 East 25th Street, New York, N.Y. 10010. Vol. 6, GAP Reports No. 66, September 1967. 64 pp. $1. Discounts on quantity orders.

Discusses the diagnosis, psychopathology, etiology, prevention, and treatment of mild mental retardation in children and adults (persons with IQ's of 50–70) and examines some legal questions and community problems related to patient care and family counseling.

A PREKINDERGARTEN PROGRAM FOR FOUR-YEAR-OLDS: with a review of the literature on preschool education. Ruth A. Bouchard and Bernard Mackler. Center for Urban Education, 33 West 42d Street, New York, N.Y. 10036. November 1967. 50 pp. 25 cents. Discounts on 21 or more copies.

Discusses the results of a 9-month study of the behavior and performance of 15 four-year-old children in a Headstart program in Harlem in relation to the findings of similar studies of other preschool programs.

READERS' EXCHANGE

SPECHT *et al*: *Neighbor to neighbor*

I was particularly interested in the article by Harry Specht, Arthur Hawkins, and Floyd McGee entitled "The Neighborhood Subprofessional Worker," and the comments following it (CHILDREN, January–February 1968) because my agency sponsors two neighborhood service projects supported by the Office of Economic Opportunity and employs 11 full-time and 90 part-time subprofessional workers from the poverty-stricken neighborhoods being served. These workers have been used to identify the unemployed and underemployed and inform them about employment resources, follow up on persons who have had difficulties on the job, recruit members for neighborhood councils and committees, work on the staffs of such councils and committees, serve as school aides and promote improved communication between schools and families, and supervise "tot-lots" and recreation programs.

For the past 3 years, our experience with subprofessional workers in such assignments have been more than satisfactory. However, we find the observations that Pearl and Riessman made in their book, "New Careers for the Poor" (The Free Press, New York), to be valid. Job descriptions *do* need to be specific and related to the workers' limitations and potentials. Close supervision *must* be provided. Opportunities for advancement *are* important. Inservice training *is* essential but *cannot* serve as a substitute for professional education on the graduate level.

We have encountered some problems in using neighborhood workers that have identified some danger points:

1. For some persons, "a little knowledge is a dangerous thing," and they may develop the attitude, "Who needs the pros?"

2. The professional person's ability to contribute service may be negated by the subprofessional worker's feeling that only the poor can really understand the poor.

3. Pressure may be applied to deal with symptoms and immediate problems instead of seeking to discover and treat the roots of problems.

4. Tendencies of subprofessional workers to identify with the persons who are seeking help may need to be dealt with before they can be objective in helping others.

5. Difficulties in maintaining respect for the confidentiality of information may arise.

6. The subprofessional workers' own needs may dominate their efforts.

But we have also found that the following advantages can come from the involvement of neighborhood residents in the agency's work:

1. A stronger identification among the other residents of the neighborhood with the agency may result.

2. The services developed are more likely to be related to the neighborhood's greatest needs.

3. Agency goal-setting is more likely to be realistic and related to its clients' potentials.

4. The agency efforts is likely to reach persons with the severest problems and greatest needs.

5. For the subprofessional workers, the work experience can provide some needed work discipline and skills, can motivate them to seek additional training and employment in private industry, and can provide them with needed employment references.

6. The neighborhood worker's identification as a staff member plus a sense of adequate performance can strengthen his self-respect, a quality without which any helping is difficult if not impossible.

Finally, the professional worker himself may benefit. Subprofessional workers can relieve him of assignments not requiring his special professional skill. They can show him that poor people have areas of strength as well as problems; that poor people and subprofessional workers cannot be stereotyped any more than professional workers; that potential for growth and change varies from person to person; that the reasons for poverty are numerous; and that subprofessional workers may in some respects be superior to professional persons. What each does needs to be related to what each has to give.

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BURGESS: *A short-sighted approach*

As Linda Burgess points out in her article, adoption agencies have for too long operated as though the unwed father was "an elusive ghost." ["The Unmarried Father in Adoption Planning," CHILDREN, March–April 1968.] As a consequence, our experiences with unwed fathers and our understanding of him as a person are still limited. Mrs. Burgess, I feel, reflects this when she states: "The agency's chief purpose in interviewing the father is to gather detailed information on his background and personality in order that selection of adoptive parents for his child may be intelligently related to the child's heredity." Although unwed fathers may respond to this appeal, it is a short-sighted approach if it does not provide services for the unwed father and his parents.

Mrs. Burgess refers to the practice of "matching" baby and adoptive parents. The importance of this practice to adoption planning needs reappraisal. Efforts on the part of many adoption agencies to find homes for multiracial and hard-to-place children point away from a matching concept and toward a need to help adoptive parents to a greater acceptance of differences. Still a better understanding of the unwed father as a person, of how he has dealt with his problems, of his relationship with the unwed mother, and of how they have arrived at decisions regarding the baby and their own futures are of prime importance to the social worker in helping adoptive parents understand better *their* attitudes and feelings toward both biological parents of their child.

As we further our understanding of parenthood out of wedlock and all its

ramifications, we cannot help but see the unwed father as a person in need of help with many of the same problems as the unwed mother. This makes it necessary for adoption agencies to find ways of integrating their efforts in his behalf with their efforts in behalf of the unwed mother. Moreover, unless meaningful casework services are made available to unwed fathers, any effort to prevent out-of-wedlock births can only hope to be 50 percent effective, at best.

Mrs. Burgess is to be commended for recognizing and doing something about the need to include the unwed father in adoption planning. It would be unfortunate, indeed, if the services she describes are not eventually expanded to provide the same quality of help to unmarried fathers as are now provided to unmarried mothers.

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GALLAGHER: *Hope for the retarded*

Ursula Gallagher has written an arresting article in the January–February 1968 issue of CHILDREN ["The Adoption of Mentally Retarded Children"]. Her emphasis on the *mildly* retarded, rather than on the *profoundly*, *severely*, or even *moderately* retarded, should help clarify the need for a high degree of selectivity in efforts to bring about adoption for the mentally retarded.

Her emphasis on the skill needed in identifying and encouraging applicants who have potential to adopt retarded children and her list of qualities adoptive parents of the retarded should have are much needed by the field of practice.

Her emphasis on the need for enough flexibility in agencies' adoptive practices for them to include single persons as adoptive parents should encourage agencies to go in that direction.

To Miss Gallagher's stimulating case illustrations, I should like to add one from my own agency in which the adoption took place some 20 years ago. Helen was 10 years of age when adoptive placement was considered. She was an extremely attractive child with a high degree of social adaptability, but with an IQ that indicated she could progress no further than the fifth grade. Helen was adopted by a "giving" couple, but a couple who also wished to "get." She met their need for a physically attractive, highly adaptable child. Helen later married a stable young man, the son of the town banker, and has been a good mother to her children, all of whom have normal intellectual capacity.

My point is that many "mildly retarded" children have much to "give" adoptive parents in affection, social adaptability, and physical appearance. It is to be hoped that the child welfare agencies will embark on further efforts toward finding adoptive parents for such children. If the adoption agencies obtain pertinent knowledge of the genetic background of the children involved, identify the potential strength of adoptive applicants, help practitioners overcome their feelings about handicaps, and exercise a high degree of skill in the selection of adoptive homes, many more "mildly mentally retarded" children should find permanent homes through adoption.

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Some questions

The term "unadoptable children" needs constant redefinition. In her article, "The Adoption of Mentally Retarded Children," Miss Gallagher argues cogently that the mildly retarded child is adoptable. Although I am in basic agreement with her position, nevertheless, the article brings certain questions to mind.

Foremost is the question of diagnosis. If *mildly* retarded children are adoptable but probably not *moderately*, *severely*, or *profoundly* retarded children, adoption agencies need increased knowledge and skill to make such distinctions as early and as nearly accurate as possible.

Early diagnosis is difficult since the main diagnostic tool is the child's development as perceived over a span of time. By the time an agency is comfortable with the assessment of the degree of retardation, the adoption of the child has become complicated by the child's age. Then, as in the first case example given by Miss Gallagher, the adoption of the child by the foster family with whom he is living ought to be the first avenue explored. Converting foster homes to adoptive homes (with a subsidy if needed) is one of the most useful ways of facilitating the adoption of hard-to-place children.

A second question relates to the availability of *enough* adoptive homes for all the mildly retarded children who need them. I am certain such homes exist and fairly hopeful that they exist in larger numbers than we know. Miss Gallagher suggests certain qualities she would expect in couples capable of being successful adoptive parents of a mentally retarded child. Many of these qualities would be those that would enable a couple to successfully adopt other hard-to-place children too. Are there enough such couples for all of these children or enough couples who could be unusually successful with a retarded child? I am not suggesting that we should seek less diligently for homes for retarded children, but only speculating about the size of the reservoir.

And, finally, the recruitment and study of the prospective adoptive parents and the accurate evaluation of the children raise questions about the use of staff and money. The adoption placement of a mentally retarded child is more difficult, more expensive, and more time-consuming than the placement of a normal one. At a time of critical staff and budget shortage, who should undertake it? Once again I am struck with the paradox in the way services are provided in so many communities. Relatively stable and highly trained staffs of private agencies are busy with the easier tasks—placing normal white infants—while public agencies with larger caseloads and greater problems in securing and keeping highly trained staff are dealing as best they can with the hard-to-place. Clearly the situation ought to be reversed.

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Correction

Decimal points were inadvertently omitted from a sentence in Gunnar Dybwad's article, "Who are the Mentally Retarded?" in the March–April 1968 issue of CHILDREN. It should read: "We know that in the so-called developed countries between .1 and .2 percent of the population—in other words, one to two persons per thousand—are so retarded as to require residential care under present circumstances."

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LEGAL BIBLIOGRAPHY FOR JUVENILE AND FAMILY COURTS: supplement 1. William H. Sheridan and Alice B. Freer. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Children's Bureau. 1967. 34 pp. 30 cents.

This first annual supplement to a bibliography published in 1966 lists over 260 law reviews, articles, case decisions, and conference and program reports on, among other subjects, child abuse, delinquency, constitutional law, domestic relations, family court and family law, law and the indigent, and the courts.

THE CHALLENGE OF CRIME IN A FREE SOCIETY and TASK FORCE REPORT: JUVENILE DELINQUENCY AND YOUTH CRIME: report on juvenile justice and consultant's papers. Task Force on Juvenile Delinquency, President's Commission on Law Enforcement and Administration of Justice. 1967. 312 pp., $2.25; 428 pp., $2, respectively.

The first is the general report of the President's Commission on Law Enforcement and Administration of Justice. The second, an expansion of the Commission's discussion of the juvenile court, presents sections of the first report concerning the prevention of delinquency and papers prepared by consultants to the Commission on the juvenile court as an institution, the culture of young people, delinquency and the schools, economic factors in delinquency, and other relevant subjects.

SELECTED READING SUGGESTIONS FOR PARENTS OF MENTALLY RETARDED CHILDREN. Compiled and annotated by Eleanor Ernst Timberg in collaboration with Kathryn Aring Gorham. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Children's Bureau. 1967. 29 pp. Single copies free from the Bureau.

Lists, with annotations, 85 publications on various aspects of mental retardation, including associated handicapping conditions, growth and development of retarded children, management at home, education and training, adolescence and young adulthood, guardianship, and recreational programs.

A CAREER IN CHILD WELFARE: what it offers you. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Children's Bureau. 1967. 8 pp. Copies free in quantity from the Bureau.

Briefly outlines the major services in the child welfare field, the duties and qualifications of a child welfare worker, the employment opportunities in the field, and the availability of grants for graduate training in child welfare.

NEONATAL NARCOTIC ADDICTION. Jane S. Lin-Fu, M.D. Department of Health, Education, and Welfare, Welfare Administration (now Social and Rehabilitation Service), Children's Bureau. 1967. 11 pp. Single copies free from the Bureau.

Summarizes data from the literature on neonatal narcotic addiction in infants born to mothers who were narcotic addicts during pregnancy.

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